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RESULTS OF PREFRONTAL LEUCOTOMY

A PRELIMINARY REVIEW OF 22 CASES

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The operation of prefrontal leucotomy has become an established, though much criticized, procedure in the treatment of psychiatric illness. Despite the fact that it is being resorted to with greater frequency, the technique of the operation has not been standardized and techniques vary widely in different surgical hands. Reports of results have been issued in Britain and in the United States of America, but as yet no reports on results in South Africa have been published. It is felt that in such a highly controversial operation, the time has come when the results of cases treated in the Department of Neurosurgery at the General Hospital, Johannesburg, should be reviewed.

In the years 1947 to 1950, no less than 63 operations were performed. A follow-up on all these cases was attempted by circularizing the patients by letter to report for interviews, with the nearest relatives, to the Depart-

TABLE I

	Sex	*Age (Years)*	*Pre-Operative Diagnosis*	*Date of Operation*	*Persisting Symptoms of Illness*	*Status—Social*	*Work*	*Pleasure*	*Bad Features*	*Result*
R.C.	M.	42	Headaches and hypertension	1 September 1950	Relieved	Recovered	Full	Full	None	Successful
C.O.K.	M.	31	Schizophrenia	6 February 1948	Relieved	Recovered	Full	Full	None	Successful
E.H.	M.	21	Epilepsy and aggression	18 July 1950	Epilepsy—no change; Aggression relieved	Partial	Partial	Full	None	Partial success
D.B.	M.	21	Schizophrenia	29 January 1948	Little change	No change	None	Partial	None	Failure
J.M.	M.	16	Epilepsy and aggression	5 March 1947	No change	No change	Partial	Full	None	Partial success
J.A.C.	M.	48	Thalmic pain	23 September 1949	No change	Recovered	Full	Partial	Mild	Failure
H.V.A.	F.	49	Parkinsonism and trigeminal pain	16 December 1947 5 April 1949	Relieved of pain	Recovered	Partial	Partial	None	Partial success
W.B.	F.	41	Agitated depression	August 1947 13 January 1949	Relieved	Recovered	Full	Full	None	Success
L.P.R.	M.	44	Chronic obsessional	8 March 1949	No change	Partial	None	None	None	Failure
C.M.	F.	25	Hysteria	27 July 1948	Relieved	Recovered	Full	Partial	None	Success
S.	F.	38	Agitated depression	14 March 1950	Relieved	Recovered	Full	Full	Present epilepsy	Success
J.F.R.	M.	37	Chronic obsessional	22 November 1949 18 July 1950	Relieved	Recovered	Full	Full	Present mild	Success
L.A.	F.	38	Chronic obsessional	21 April 1949	Suicide					Failure
G.J.	M.	22	Schizophrenia	April 1948	No change	Partial	Partial	Partial	None	Failure
L.F.	F.	52	Schizophrenia	15 August 1950	Relieved	Recovered	Full	Full	None	Success
D.I.	F.	39	Manic depression	1 August 1950	No change	No change	None	None	None	Failure
F.A.D.	M.	34	Schizophrenia	16 May 1950	No change	No change	Partial	None	None	Failure
J.D.	M.	82	Trigeminal neuralgia	26 April 1950	Relieved	Recovered	Partial	Full	Present mild	Success
F.J.N.	M.	41	Manic depression	19 July 1949	No change	No change	None	None	None	Failure
J.B.	F.	22	Chronic obsessional	1 August 1950	Relieved	Recovered	None	Full	Present mild	Success
B.J.	F.	26	Mental defect and behaviour disorder	August 1947	Relieved of behaviour disorder	Partial	None	Full	None	Success

ment. There was a response from 22 people. This follow-up included attempts to trace patients who were reported as being in mental hospitals.

The question of criteria of improvement or deterioration after operation arose. The most satisfactory criteria were those adopted by Strom-Olsen and McDonald Tow at the Runwell Hospital, Essen, England (1949). They graded patients into two large groups. Group C contained the chronic, severely disorder psychotics in mental hospitals suffering from schizophrenia, epilepsy, mania or depression. The prognosis of all of them was poor. Group A contained patients admitted specifically for the operation with severe neurotic depression, obsessive-compulsive neurosis, chronic tense hypochondria and all having severe symptoms necessitating operation. The criteria which were sought for after operation were:—

1. *Illness.* The assessment of the patient's symptoms, whether these were absent, improved or unchanged.

2. *Status.* The social level and adaptation which is in turn graded. 'Recovery' implies that the patient lives in his own home at ease with his family, that he takes part in everyday activities outside his home in harmony with his fellow citizens, and that he is a satisfactory social fit. Many psychotic cases, though not recovered from their illness, had better status in so far as they were more easily managed in the wards or at home.

3. *Work.* This is graded as 'full' when the patient is able to resume his accustomed employment. 'None' stands for those who do nothing. 'Partial' means performance of obviously sub-standard work, i.e. below the quality and quantity to be expected.

4. *Pleasure.* This is assessed as the ability of the patient to get enjoyment out of leisure, entertainment, amusements. 'Full' signifies its normal presence; 'None' its absence, and 'Partial' the broad range between the two.

5. *Bad Features.* Under these are included such features as gluttony, garrulousness, inertia, and we add epilepsy.

The cases referred to the Department of Neurosurgery were all carefully assessed beforehand by consultant psychiatrists for diagnosis and for suitability for operation. They were all given the necessary treatments, physical, psychotherapeutic and social, which the illness warranted, before operation was considered. In no case was the operation performed in an illness of less than two years' duration. Cases were referred for pain syndromes such as thalamic pain, intractable trigeminal neuralgia not responding to section of the nerve root; one case had severe headaches with hypertension. Follow-ups were made only after six months had elapsed since operation.

In Table I the full assessment of the 22 cases is given using the criteria discussed above.

In an all-round assessment of the cases adding all the criteria together, we may summarize our results as shown in Table II.

In this series of cases no patient had been certified and placed in mental hospital as a chronic incurable case before operation. They correspond roughly with Ström-Olsen and McDonald Tow's Group A cases with which they can be compared as shown in Table III.

It will be noted that on the whole the present group of cases compares favourably with the Group A cases of the Runwell Survey. This is especially true for the post-operative effects where, in our series, the patients tended to lose far less in the way of status, ability to work, ability to enjoy pleasure, and there are far fewer objectionable features.

TABLE II

Diagnosis	*No. of Cases*	*Complete Success*	*Partial Success*
Schizophrenia	5	2	0
Manic depression	2	0	0
Involutional depression	3	3	0
Obsessional-compulsive states	4	2	0
Epilepsy with aggressive features	3	0	2
Chronic hysteria	1	1	0
Pain syndromes	4	2	1
Mental defect with behaviour problems	1	1	0
Total	22	10	2
Percentages	100	45.5	13.6

TABLE III

	Runwell Group A Cases	*Department of Neurosurgery Cases*
Relieved of illness	76%	54%
Recovery of full social status	44%	50%
Unable to work	76%	27%
Inability to enjoy original pleasure	44%	17%
Objectionable anti-social personality deficiencies	72%	23.5%
Full remunerative employment	8%	36.5%
Share of full pleasure	12%	50%

We believe our results differ from the Runwell cases due to the variation that must be expected from different surgical techniques. In the case of prefrontal leucotomy, where no standardized procedure is employed by each surgeon or surgical team, results are bound to vary.

In three of our cases where no success was obtained within six months with one operation, the leucotomy was performed a second time using a more radical incision. In all three cases success was obtained after the second operation. To our knowledge, no reports of results of repeat incisions have come to hand.

In view of the fact that in 45.5% of cases our results are highly successful and in 13.6% of cases our results are partially successful, we feel that the operation has a definite place in psychiatric therapy. We would agree with Ström-Olsen and McDonald Tow that the operation has unequivocal indications in the chronic psychosis with severe disorders of behaviour, in chronic obsessional-compulsive states and in depressive states of an intractable type with prolonged and total incapacity. In all cases the operation must be used with discretion.

SUMMARY

1. This report consists of a follow-up of 22 cases of psychiatric and neurologic disability requiring prefrontal leucotomy.

2. The follow-up covered cases operated on in the years 1947 to 1950 inclusive. In all cases at least six months were allowed to elapse before an assessment was made.

3. The criteria of the follow-up were those used by

Ström-Olsen and McDonald Tow at Runwell Hospital, Essen.

4. In our group 45.5% of cases were successfully relieved and 13.6% of cases were partially successful in terms of these criteria.

The results compare favourably with the comparable Runwell group.

5. In three cases a second leucotomy was performed after the first had previously failed, with excellent results.

6. The operation has a definite and valuable place in the treatment of chronic psychosis with severe behaviour disorder and chronic intractable obsessional and depressive states with prolonged and total incapacity.

In all cases it must be used with discretion.

The author wishes to express his sincere thanks to Mr. R. A. Krynauw for permission to investigate the cases, and for kind encouragement and advice throughout. He would also like to express his gratitude to Mr. K. L. Allen for his many useful suggestions.

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Ström-Olsen, R. and Tow, P. McDonald (1949): Lancet, **256**, 87.

CORROSIVE OBSTRUCTION OF THE STOMACH

WITHOUT INVOLVEMENT OF THE OESOPHAGUS

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Cape Town

The oesophagus bears the greatest brunt after the swallowing of corrosive poisons. Stricture formation often occurs at a later date. In most cases the stomach shows no evidence of involvement. Less commonly, both the oesophagus and the stomach undergo stricture formation. Rarely, however, does the stomach alone become stenosed, leaving the oesophagus normal.

A young married woman aged 29 years was referred to me with a complaint of persistent vomiting. Five months before she had accidentally swallowed about 1 oz. of concentrated hydrochloric acid. She experienced severe epigastric pain, followed by vomiting and violent purging. The acute phase lasted for a week, during which she brought up blood and had a great deal of pain after meals. As time went on she had increasing difficulty in retaining her food and could eat only small amounts at each meal. At the time of examination, both solids and liquids could not be retained.

She was a thin, emaciated subject who had lost 38 lb. in weight and felt tired and listless. The abdomen was scaphoid and the skin loose and inelastic. There was slight tenderness in the epigastrium to the left of the midline, but no mass was palpable. The blood picture revealed a normal haemoglobin and red cell count.

The barium meal X-ray revealed the following interesting features: The mucosal pattern of the oesophagus was normal; no stricture was present (Fig. 1). The stomach, however, was small and contracted, allowing only a thin trickle of barium to flow through the antrum (Fig. 2). The barium was retained in the stomach for 36 hours, showing marked delay in emptying.

After several days of intravenous therapy whereby fluids, electrolytes and proteins were partially restored, she was considered fit to undergo surgical treatment. The abdomen was opened through a right upper paramedian incision and a small, contracted tube-shaped stomach, tucked away under the left costal margin, was seen. The stomach wall was thickened and had the appearance of wet blotting-paper. A few soft 'inflammatory' glands were palpable on the leser curvature. The damage involved practically the whole viscus from the pylorus to the cardiac orifice of the stomach.

A total gastrectomy was performed and a loop of jejunum brought up to the oesophageal end. A splenectomy had previously been done to reduce the bleeding and to facilitate subsequent operative procedures. The abdomen was closed by interrupted silk sutures after leaving a small drain down to the anastomosis.

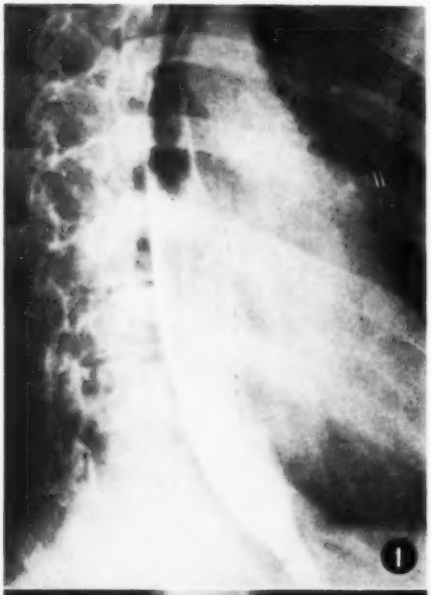
She made an uneventful recovery and was eating normal meals 14 days after the operation. The main complaint was that she was always hungry and not receiving sufficient food. Four weeks after the operation she had regained 15 lb. and was feeling perfectly well.

The stomach dimensions were most interesting (Fig. 3). It is small and contracted and measures 4½ inches in length before fixation in formalin. Fig. 4 shows gross thickening of the stomach wall. The haemorrhagic changes and oedema of the mucosa is also apparent.

DISCUSSION

Very few cases have been recorded, in the British literature, of corrosive strictures of the stomach without involvement of the oesophagus. Vinson and Harrington [1] described a case of a man who swallowed formaldehyde and subsequently developed signs of obstruction in the stomach without involvement of the oesophagus. Schulenburg [2] described a case of a man of 52 who swallowed 1 oz. of concentrated hydrochloric acid. A month later a narrowing of the distal portion of the stomach was demonstrated, without involvement of the oesophagus. At operation a fibrous stricture 2 inches proximal to the pylorus was found with dilatation above it. An anterior gastro-jejunostomy was performed and the patient made an excellent recovery.

This case differs from Schulenburg's in that the whole stomach, except for a small portion near the cardiac orifice, was involved. The viscus was small, its wall



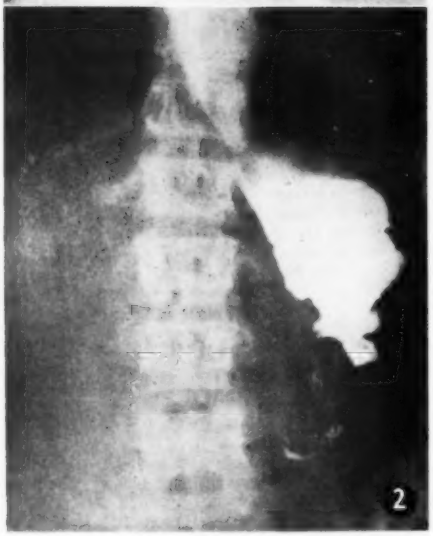


Fig. 1. Barium swallow showing the normal appearance of the oesophagus.

Fig. 2. To show the small stomach with some barium in the proximal part. The distal portion is stenosed, allowing the passage of only a trickle of barium.

markedly thickened and oedematous, and was situated high up under the left costal margin. These features strongly affected the method of surgical treatment to be adopted. Gastrojejunostomy, which proved a highly successful procedure in Schulenburg's case, was bound to fail here. A total gastrectomy was therefore deemed advisable leaving a drain down to the site of the anastomosis to safeguard against leakage.

The majority of cases of corrosive poisoning have been recorded by foreign authors, e.g. Pop and Galdau,[3] Orator [4] and Petrov.[5] Their conclusions are as follows:—

1. Acid burns are more liable to cause gastric stenosis than alkalis, which affect mainly the oesophagus.

2. The site of stricture formation is almost invariably the pyloric and pre-pyloric regions.

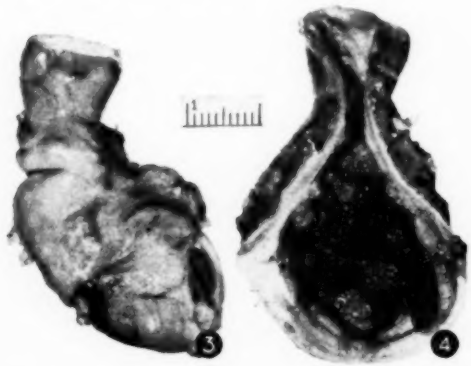


Fig. 3. The whole stomach, measuring 4½" in length, can be seen.

Fig. 4. The stomach has been opened longitudinally, and shows a haemorrhagic mucous membrane and a markedly thickened and fibrotic muscular wall.

3. The surgical procedures for relief are determined by the stage at which the patient is seen. In the earliest stages, with gross damage to the stomach, jejunostomy is the operation of choice. At a later stage, when stenosis with obstruction is established, gastrojejunostomy is the only rational procedure.

Judging from the literature available, no case of corrosive poisoning had been described previously in which gastrectomy had been performed.

I wish to thank Dr. W. P. Steenkamp (Jr.) for his advice and co-operation and Dr. J. Siebert, Dr. R. Tobias and Dr. G. J. v. d. Merwe of Beaufort West, for referring the case to me.

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2. Schulenburg, C. A. R. (1941): Lancet, **2**, 367.
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5. Petrov, B. (1935): Sovetsk No. 6, p. 106.

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EDITORIAL

MATERNAL RUBELLA AND CONGENITAL DEFECTS

Since the original report was made nine years ago, a considerable body of evidence has arisen that if a pregnant woman contracts German measles early in her pregnancy, the child she bears is likely to have congenital deformities.

It was in 1941 that Gregg,[1] an Australian ophthalmologist, described 78 cases of congenital cataract following maternal rubella. Many of these children had additional deformities. There had been a severe rubella epidemic during the previous year, and it was suggested that this illness in the pregnant woman caused congenital defects in her child. Subsequent investigations strengthened the hypothesis: the children, if not still-born, had defects of the eyes, ears, teeth or heart. This evidence has received serious attention, for if it could be proved that rubella was responsible for congenital defects, the discovery would provide the first opportunity for a method to prevent such defects. Beeson [2] has recently expressed the opinion that the evidence 'is now conclusive'.

Martin [3] investigated 102 deaf children born after a wide-spread epidemic of rubella in England in 1940. She found that in 36 cases the mothers had rubella during the first four months of pregnancy, and six others probably suffered from rubella. In many of these children there were also defects of the eyes, and in a few of the heart.

Abel and van Dellen [4] attempted to discover the numerical probability of congenital defects in children born to mothers who had had rubella during pregnancy. Through the medium of a syndicated health column, information was obtained of 81 living children whose mothers had had rubella. Of these, 25 were normal and 56 abnormal. Nineteen children had congenital heart disease, 17 cataracts, 14 deafness, seven mental defect and five malformed teeth.

The occurrence of congenital defects after rubella appears to be more than coincidental. The rate of babies with congenital abnormalities born of mothers who had rubella in pregnancy is estimated to be 10 times greater than that for congenitally deformed babies in the population at large.[5]

Although statistical studies such as this strengthen the hypothesis, there are further considerations which must be borne in mind. Inquiry for the infection is naturally

1. Gregg (1941): Trans. Ophth. Soc. Austral., **3**, 35.
2. Beeson (1950): *Year Book of Medicine*, p. 21. Chicago: The Year Book Publishers.
3. Martin (1946): Lancet, **1**, 479.
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5. Conte *et al.* (1945): Amer. J. Dis. Child., **70**, 301.

VAN DIE REDAKSIE

RUBELLA BY VERWAGTENDE MOEDERS EN AANGEBORE GEBREKE

Sedert die oorspronklike verslag nege jaar gelede uitgebring is, het 'n aansienlike hoeveelheid getuienis aan die lig gekom wat daarop dui dat wanneer 'n swanger vrou vroeg gedurende haar swangerskap Duitse masels kry, die kind aan wie sy geboorte skenk waarskynlik aangebore liggaamsgebreke sal hê.

Dit was in 1941 dat Gregg,[1] 'n Australiese oogarts, 78 gevalle beskryf het van aangebore witstaar nadat die moeder rubella gehad het. Baie van hierdie kinders het addisionele liggaamsgebreke gehad. Daar was gedurende die vorige jaar 'n hewige rubella-epidemie en die moontlikheid is geopper dat hierdie siekte van die swanger vrou aangebore liggaamsgebreke by haar kind veroorsaak. Ondersoeke wat daarna gedoen is, het hierdie hipotese versterk: die kinders, wanneer hulle nie dood gebore word nie, het gebreke aan die oë, ore, tande of hart. Ernstige aandag is aan hierdie getuienis geskenk, want indien dit bewys kon word dat aangebore gebreke aan rubella te wyte is, sou die ontdekking die eerste geleentheid bied vir 'n metode om sulke gebreke te voorkom. Beeson [2] het onlangs die mening uitgespreek dat die getuienis ‚nou afdoende is'.

Martin [3] het 102 dowe kinders ondersoek wat in 1940 na 'n wydverspreide rubella-epidemie in Engeland gebore is. Sy het gevind dat die moeders in 36 gevalle gedurende die eerste vier maande van swangerskap rubella gehad het en dat ses ander waarskynlik aan rubella gely het. By baie van hierdie kinders was daar ook gebreke aan die oë en by 'n paar aan die hart.

Abel en van Dellen [4] het die waarskynlikheidsyfer van aangebore gebreke probeer bepaal in die geval van kinders van moeders wat gedurende swangerskap rubella gehad het. Deur middel van 'n gesondheidsrubriek in 'n aantal blaaie is inligting verkry oor 81 lewende kinders wie se moeders rubella gehad het. Van hulle was 25 normaal en 56 abnormaal. Negentien kinders het aangebore hartkwaal gehad, 17 witstaar, 14 was doof, sewe was verstandelik agterlik en vyf het misvormde tande gehad.

Dat aangebore gebreke na rubella voorkom, skyn nie bloot toevallig te wees nie. Die verhouding van babas met aangebore gebreke uit moeders gebore wat gedurende swangerskap rubella gehad het, word geraam op 10 keer groter as dié ten opsigte van babas met aangebore gebreklikheid onder die algemene bevolking.[5]

Alhoewel statistiese ondersoeke soos hierdie krag aan die hipotese verleen, is daar verdere oorwegings wat in

1. Gregg (1941): Trans. Ophth. Soc. Austral., **3**, 35.
2. Beeson (1950): *Year Book of Medicine*, bl. 21. Chicago: *The Year Book Publishers*.
3. Martin (1946): Lancet, **1**, 479.
4. Abel en van Dellen (1949): J. Amer. Med. Assoc., **140**, 1210.
5. Conte *et al.* (1945): Amer. J. Dis. Child., **70**, 301.

retrospective, and mothers with afflicted children are likely to give an inquiry more serious attention. Negative cases are thus overlooked. It is now evident that the original conclusion was unduly pessimistic, for maternal rubella does not invariably result in congenital defects. This is illustrated by Abel and van Dellen's series, and also by the report of Fox and Bortin,[6] which describes numerous normal babies born of women who had had rubella during the early months of pregnancy.

Following an attack of rubella, the pregnancy may in many cases terminate in abortion[7]; the mother may be prematurely delivered of a macerated foetus, or of a still-born child with deformities; the child may be born at term and may be either deformed or normal.

It is not always easy to be certain that the maternal disease was, in fact, rubella, and proof is provided only if the virus was recovered at the time of the attack. It is uncertain that rubella can be transmitted to laboratory animals. Türck cells in the blood, formerly regarded as diagnostic of rubella, can also be found in other conditions. The diagnosis has to be made on clinical grounds by exclusion of the diseases which resemble rubella. Scarlet fever and glandular fever present the most difficulty.

Infection during the early months of pregnancy may cause such grave injury to the embryo because it operates at the time of greatest differentiation and most rapid development. The stage of embryological growth at which the virus is active determines the type of malformation which will occur. Brown[8] has suggested that the primary influence is on the foetal adrenal medulla, with secondary involvement of the brain and other structures. It is, however, remarkable that no other virus has a similar effect on foetal tissue. There has been no report in the medical literature to suggest that any other disease results in congenital malformations.[9]

Some workers consider the evidence sufficient to warrant therapeutic abortion in pregnant women who contract German measles. Wesselhoeft[10] firmly advises that if spontaneous abortion threatens during or after the illness, no treatment should be instituted to prevent it.

Therapeutic abortion, when the mother's life is not endangered, is probably illegal in South Africa, as in many other countries. But the law should become altered to benefit the community if sufficient medical knowledge accumulates to convince the public that abortion in maternal rubella is a means of preventing tragic deformities. It is clearly in the interests of society and the family to prevent tainting of the foetus, where this is possible.

The general practitioner must be intensely aware of the serious consequences of German measles during early

6. Fox and Bortin (1946): J. Amer. Med. Assoc., **130,** 568.
7. Swan (1948): Lancet, **1,** 744.
8. Brown (1947): Northwest Med., **46,** 288.
9. Wesselhoeft (1947): New Eng. J. Med., **236,** 978.
10. Wesselhoeft (1949): New Eng. J. Med., **240,** 258.

gedagte gehou moet word. Ondersoek na die siekte is natuurlik retrospektief en moeders met gebreklike kinders sal waarskynlik ernstiger aandag aan 'n ondersoek skenk. Negatiewe gevalle word dus oor die hoof gesien. Dit is nou duidelik dat die oorspronklike gevolgtrekking te pessimisties was want rubella by die moeder het nie sonder uitsondering aangebore gebreke tot gevolg nie. Dit word deur Abel en van Dellen se reeks aangetoon en ook deur die verslag van Fox en Bortin[6] wat talle normale babas beskryf wat uit vroue gebore is wat rubella gedurende die eerste maande van swangerskap gehad het.

Na 'n aanval van rubella kan swangerskap in baie gevalle met 'n miskraam eindig; die moeder kan 'n masereerde fetus of 'n doodgebore kind met liggaamsgebreke in die wêreld bring; die kind kan ter bestemder tyd gebore word en kan gebreklik of normaal wees.

Dit is nie altyd maklik om seker te wees dat die siekte van die moeder inderdaad rubella was nie en bewys word alleen verskaf indien die virus ten tyde van die aanval gevind word. Dit is onseker of rubella op proefdiere oorgedra kan word. Türck-selle in die bloed wat voorheen as kentekenend van rubella beskou is, kan ook by ander siektetoestande aangetref word. Die diagnose moet om kliniese redes gemaak word deur die uitsluiting van siektes wat ooreenkoms met rubella vertoon. Skarlakenkoors en klierkoors lewer die meeste moeilikhede op.

Besmetting gedurende die vroeë maande van swangerskap kan sulke ernstige beskadiging van die embrio veroorsaak omdat dit gedurende die tydperk van grootste differensiëring en vinnigste ontwikkeling inwerk. Die stadium van embriologiese groei waarin die virus optree bepaal die misvorming wat sal voorkom. Brown[8] het aan die hand gedoen dat die primêre invloed op die bynierkern van die fetus uitgeoefen word en dat die brein en ander strukture sekondêr betrokke is. Dit is egter merkwaardig dat geen ander virus 'n soortgelyke uitwerking op die weefsel van die fetus het nie. Daar is tot dusver geen melding in geneeskundige literatuur gemaak van enige ander siekte wat aangebore misvormings tot gevolg het nie.[9]

Sommige navorsers meen dat die getuienis toereikend is om terapeutiese miskraam by swanger vroue wat rubella kry, te regverdig. Wesselhoeft[10] sê sonder aarseling dat indien spontane miskraam gedurende of na die siekte dreig, geen behandeling toegepas moet word om dit te verhoed nie.

Terapeutiese miskraam is waarskynlik onwettig in Suid-Afrika, soos in baie ander lande, wanneer die moeder se lewe nie in gevaar is nie. Maar die wet moet gewysig word sodat die gemeenskap bevoordeel kan word indien genoeg mediese kennis opgedoen kan word om die publiek te oortuig dat miskraam in die geval van rubella by die moeder 'n middel is om tragiese misvormings te voorkom. Dit is klaarblyklik in belang van die maatskappy en die gesin dat besmetting van die fetus voorkom moet word waar dit moontlik is.

Die geneesheer moet ten sterkste bewus wees van die ernstige gevolge van rubella gedurende vroë swangerskap.

6. Fox en Bortin (1946): J. Amer. Med. Assoc., **130,** 568.
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pregnancy. It is wise at this stage to use all available means of prophylaxis. Pregnant women should strenuously avoid exposure to the illness; unfortunately rubella is infectious before the rash appears. Research is required to find an adequate immunizing factor. Pooled serum and gamma globulin may provide temporary immunity, but are of limited value, for the foetus will already have suffered the infection when it is clinically evident that the woman has rubella. It has even been suggested that all women should be exposed to the infection before marriage.

Dit is verstandig om op hierdie stadium alle beskikbare voorbehoedingsmetodes te gebruik. Swanger vroue moet ten alle koste blootstelling aan die siekte vermy; ongelukkig is rubella aansteeklik voordat die uitslag te voorskyn kom. Navorsing is nodig om 'n toereikende immuniseringsfaktor te vind. Gemengde serum en gammaglobulien mag tydelike immuniteit skenk maar is van beperkte waarde want die fetus sal reeds aangetas wees wanneer dit klinies duidelik word dat die vrou rubella het. Daar is aan die hand gedoen dat alle vroue aan besmetting blootgestel moet word voordat hulle trou.

BRUCELLA MELITENSIS INFECTION

PRESENTING AS AN ARTHRITIS OF THE HIP JOINT

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In 1910 Garrow,[1] of Steytlerville, Cape Colony, recorded a case of undulant fever followed by hip joint disease, requiring prolonged rest in bed with extension.

In 1911 Strachan[2] presented to the University of Glasgow a thesis on 268 cases of undulant fever due to *Brucella melitensis*. Joint swellings or effusions occurred in 15.3% of these cases. There have been a few similar reports since that time. Monarticular arthritis is uncommon. Apparently only two cases of hip joint arthritis in which positive cultural evidence of Brucella infection has been obtained, have been reported:—

In 1933 O'Donoghue[3] published the case of a girl of 12 years, who after three months of fever developed severe pain in the right hip joint. At operation a large amount of thin pus was obtained and from this pus *Brucella melitensis* was grown. Healing occurred with complete bony ankylosis.

In 1949 Coventry *et al.* described a case of infection of the hip by *Brucella suis* in a 22-year-old farmer who, 11 weeks before admission to hospital, had complained of the sudden onset of severe pain in the right thigh. Movements of the right hip were painful. Blood cultures at 11 days, three months and six months were negative, as was culture of the joint fluid, but synovial biopsy gave a positive culture for *Brucella suis*. Complete recovery followed.

The following case presented as an arthritis of the hip joint in which *Brucella melitensis* infection was proved by blood culture.

C.C., a coloured male aged 11 years, of Rehoboth, South West Africa, was admitted to Groote Schuur Hospital on 13 March 1950, complaining of pain in the left hip joint for the past 13 weeks. He was in good health until one morning in December 1949, when he awoke to find that his left hip was slightly painful and this resulted in his limping when he walked.

One week later he felt feverish, perspired more freely than normal; this was accompanied by lassitude. The pain in the hip and the feverishness persisted until February 1950, when he was seen by an orthopaedic surgeon and considered to be a case of tuberculous hip disease. After immobilization in a plaster spica, the patient was admitted to a local orthopaedic institution, where it was noticed that he was running a remittent temperature, rising to 102°–103° F in the evening. He was sent in for investigation of this pyrexia. Throughout this illness the pain was confined to the left hip. There was some alleviation after plaster immobilization.

There was nothing relevant in the past, or the family history. Appetite remained good, but he had considerable flatulence. Diet was always adequate, and he was very partial to goat's milk, of which he consumed large quantities.

Physical Examination. He was a thin, ill-looking, Coloured boy with both legs immobilized in a plaster spica. There was slight pallor of the mucous membranes. The temperature was 103° F; pulse 130 per minute. No abnormality was detected on physical examination.

Urine. Normal chemically and microscopically.

Blood. Haemoglobin (Spencer) 12.5 G.%; erythrocytes 4.2 million per c.mm.; packed cell volume 40%; leucocytes, 6,000 per c.mm. polymorphs, 43%; lymphocytes, 51%; monocytes, 5%; eosinophils, 1%; erythrocyte sedimentation rate, 42 mm. (Wintrobe.)

Additional Investigations: E.C.G., Normal.

Blood Culture (1950):—

13 March. Growth of *Brucella melitensis* after 14 days' incubation.

21 March. Growth of *Brucella melitensis* after 8 days' incubation.

14 April. No growth after 6 weeks' incubation.

4 July. No growth after 5½ weeks' incubation.

Serology:—

14 March. Brucella agglutination, negative.

17 March. Wassermann reaction, negative.

24 March. Brucella agglutination, negative.

24 March. Widal reaction, negative.

15 April. Brucella agglutination, positive to a titre of 1:200 for *Brucella abortus* and 1:800 for *Brucella melitensis*.

26 May. Brucella agglutination, titre insignificant.

4 July. Brucella agglutination, positive for *Brucella abortus*, 1:200; for *Brucella melitensis*, 1:800.

Biochemistry:—

	29 April 1950	*20 May 1950*
Serum van den Bergh (direct and indirect)	Negative	—
Serum Albumin	4.8 G./100 mls.	—
Serum Globulin	2.9 " " "	—
Total Protein	7.7 " " "	—
Thymol Turbidity	5.5	3.5
Colloidal Gold	3.0	1.0
Thymol Flocculation	3.0	1.0

X-ray Investigations of the chest showed slight apical pleural thickening; and of the hips (on 31 January, 24 March, 14 April, 12 May) revealed no abnormality.

Course. This is illustrated in Fig. 1.

By the end of the first week the temperature appeared to be subsiding. The patient was asymptomatic and physical examination revealed no abnormality. The plaster spica was split to allow a change to an abduction frame and two super-

ficial bed sores were found. The hip movements were limited owing to stiffness.

On 31 March 1950 a blood culture taken on 14 March 1950 was reported as positive for *Brucella melitensis* and treatment was started with aureomycin 1.5 gm. per 24 hours. This was discontinued after five days (total 7.5 gm.). The temperature subsided completely and on 12 April, the E.S.R. was 4 mm. (Westergren). The patient was moving his legs freely but had not commenced weight bearing.

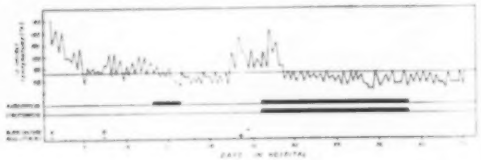

FIG. 1

On 13 April he complained of sudden severe pain in the opposite hip. All movements were extremely painful and there was a warm, indefinite swelling in that region. The temperature was again raised and the pulse fast. The hip joint was aspirated and some chocolate-looking fluid obtained, culture of which proved negative.

Aureomycin 0.5 gm. 8-hourly and Streptomycin 0.5 gm. *b.d.* was given for three weeks. The leg was kept in extension by skin traction and within 48 hours the pain had diminished; 48 hours later the temperature had subsided. His progress from then on was uneventful. The sedimentation rate settled and by 13 May there was only slight limitation of flexion and internal rotation of the right hip. He left hospital symptom free and walking well on 5 June 1950.

He was seen again in July 1950. He was very fit and a blood culture was negative.

DISCUSSION

Brucellosis is a generalized infection in which occasionally definite evidence of localization occurs. It appears that hip joint involvement is uncommon; but it is interesting to note that radiologically the case of Coventry *et al.* showed osteoporosis of the head of the femur and evidence of an early destructive arthritis. On this account it was thought to be probably tuberculous in nature. However, unlike tuberculosis, the onset was acute and the pain severe. In the case of C. C., the onset was quite compatible with the diagnosis of tuberculous hip joint disease, and the difficulty of recognizing this as a form of Brucellosis is obvious.

Blood culture was positive on two occasions, during which time the agglutination tests were negative and only on the 32nd hospital day did they become positive. Dalrymple Champneys[5] states that agglutinins take at least five days to develop, often much longer; in one of his cases, as long as a year. Furthermore, negative agglutination zones are particularly common in this disease, leading to a negative report unless a wide range of dilutions is employed. In any event, in a given case serology should not be relied on and every effort made to isolate the organism from blood, bone marrow, or (as in O'Donoghue's case) from the joint fluid.

The patient was treated with aureomycin in the first instance, 1.5 gm. daily for five days. This apparently small dosage was given, as the child, although 11 years old, weighed only 63 lb. There was an apparent response in that the temperature subsided, but it was followed one week later by a relapse involving the opposite hip joint.

Chloromycetin and Aureomycin have both been employed in the treatment of Brucellosis.

Woodward *et al.*[6] treated nine cases of Brucellosis with Chloromycetin; seven of these cases showed positive blood cultures (*Br. abortus*, four, *Br. melitensis*, one, *Br. suis*, two) and they found it exerted 'specific beneficial effect', but one of the patients relapsed 31 days after discontinuation of therapy.

Walley and Cooper[7] reported a single case treated with Chloromycetin with a favourable response.

Spink *et al*[8] reported the treatment of 24 cases of Brucellosis due to *Brucella melitensis*, six of which had been treated before unsuccessfully with a combination of Streptomycin and Sulphadiazine. He found that Aureomycin alone was suppressive but not necessarily always curative. Three cases had relapsed within one to three months.

Lindeck[9] reported four cases of *Brucella abortus* (diagnosed serologically) treated with Aureomycin, with relapse in one case.

Yow and Spink,[10] as a result of their experimental work, found Streptomycin to be rapidly bactericidal, whereas Chloromycetin and Aureomycin were bacteriostatic in action. Resistance of Brucella to Streptomycin could be developed readily *in vitro*, but increased resistance to Aureomycin and Chloromycetin could not be demonstrated.

Heilman[11] demonstrated that Aureomycin or Chloromycetin was not particularly effective in reducing the numbers of Brucella in the spleens of infected mice, and that the most effective form of therapy was a combination of Aureomycin and Dihydrostreptomycin. This, however, did not eradicate all the organisms.

Herrel and Barber[12] successfully applied this to the treatment of two cases of *Brucella suis* and two cases of *Brucella abortus* (all proved by blood culture). The dosage recommended by them is Aureomycin, 3 gm. per day, 750 mgs. six-hourly, and Dihydrostreptomycin, 1 gm. *b.d.* by intramuscular injection for 12-14 days; but for those culturally proved cases with localized lesions the course should last *at least 21 days*. No claim is made that this is a specific form of therapy for Brucellosis and in view of Heilman's work *relapses may still be expected*.

Aureomycin may lead to nausea and vomiting. This may be avoided by giving a glass of milk with each dose.

Bartholomew and Nichols[13] have shown that aluminium hydroxide should not be administered simultaneously with Aureomycin, as this lowers the effective blood level. More recently Terramycin has been used successfully in the therapy of Brucellosis.

SUMMARY

A case of *Brucella melitensis* infection presenting as an arthritis of the hip joint is described.

A review of the literature reveals it to be an uncommon form of presentation, but Brucellosis should be borne in mind in considering the differential diagnosis of arthritis of the hip joint.

The immediate therapeutic response to Aureomycin alone was satisfactory, but relapse followed, and this responded satisfactorily to a combination of Dihydrostreptomycin and Aureomycin.

The antibiotic therapy of the condition is reviewed but final evaluation is not yet possible.

I wish to thank Prof. J. F. Brock for permission to publish this case.

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ADDENDUM

Since the writing of this report Herrel and Barber[14] have published further observations on the treatment of Brucellosis by means of a combination of Aureomycin and Dihydrostreptomycin. They have to date treated 35 cases of Brucellosis (25 proved culturally, and the remaining 10 patients acutely ill with 'unmistakable evidence of Brucellosis'). In this group there was *one symptomatic relapse*, but no instance of bacteriologic relapse over a period of three to 19 months.

DEAF-MUTISM IN CHILDREN

WITH SPECIAL REFERENCE TO THE CONGENITAL TYPE AFTER MATERNAL RUBELLA

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General Survey. Deaf-mutism results from congenital deafness, or complete loss of hearing before the age of seven years. The dumbness is secondary to defective hearing and in most congenital cases, the organ of Corti is undeveloped. (Otosclerosis occurs later in life, and the auditory nerve is intact.) Congenital deaf-mutism may actually be 'acquired' *in utero* (e.g. as in syphilis, rubella), so all congenital deaf-mutism is not necessarily hereditary in origin. As many deaf-mutes are educated in special schools, they often meet and marry deaf partners. From a eugenic point of view this may be better than marrying into normal families and so spreading the affliction, when the latter is of genetic origin.

Deaf-mutes occasionally exhibit retinitis pigmentosa, and more often feeble-mindedness and sterility. Hypogenitalism and infantilism are sometimes found in recessive types. One family is quoted by Gates (1946), where deaf-mutism is combined with heterochromia iridis, Horner's syndrome and strabismus.

Otitis media may cause deafness, and according to Bauer (1945) susceptibility to otitis media may be inherited, being sometimes familial. The deafness, if it occurs early, may be associated with mutism.

Gates (1946) also cites Lindborg, who believes that hereditary deaf-mutism is due to one Mendelian recessive character, and not to Plates' two factors. Love (1920) described a family with five affected generations, descended from a common ancestor, and postulates a recessive mode of inheritance.

Kraatz (1925) studied many pedigrees statistically, and came to the conclusion that deaf-mutism cannot be due to a single dominant, recessive or sex-linked character, but that the statistics pointed to the operation of two recessive factors. However, on the basis of two factors, Deaf x Deaf may give all normal children in some families, so that lack of penetrance is a more probable explanation. Persons who are heterozygous for 'deafness' can hear perfectly well on the audiometer, so the condition is recessive.

Tinkle (1933) also believes that two recessive genes are concerned with the production of hereditary deaf-mutism, but suggests that a third pair of genes control the development of the middle and internal ears.

Switzerland has the highest incidence of deaf-mutism in the world, namely 0.12% as against 0.023%, in Germany for instance (Gates, 1946). Hanhart is cited as saying that 60% of deafness in Switzerland is 'sporadic', being related to cretinism. In Sweden, where there are few cretins, the ratio of congenital to acquired deafness is estimated at 100:67. Murray and Wilson (1945) show that there is a relationship between deaf-mutism and goitre and cretinism. In three goitrous districts in Oxfordshire with low water and soil iodine content, there were 28 deaf-mutes in a population of 36,635, whereas in three non-goitrous areas there were only five deaf-mutes in 38,910. Some of the deaf-mutes have enlarged thyroids, and belong to goitrous families, but both sexes are equally affected, which does not obtain in goitre.

Also cited by Gates are Muller and Hanhart, who describe another type of labrynthine deaf-mutism with morphological changes in the ductus and sacculus, apparently inherited as a dominant, and occurring at such an early age as to cause deaf-mutism. One such family pedigree revealed 11 cases in four generations, showing dominant inheritance with 10 sibs out of 19 affected. Other instances are quoted. In one family, the child was normal, both parents deaf, and grandparents normal, indicating that the parents were carrying different forms of deaf-mutism in a recessive state. In another family, the father had white hairs in the beard, and was not deaf. His five

children were all deaf-mutes. Two of these who mated with other deaf-mutes had normal progeny. The five children had pigmentary anomalies with white patches on hair and skin, pigmentation on the body, persistent lanugo on the back and mongoloid features. There were 19 deaf-mutes in four generations, and eight cases (six of them deaf-mutes) of pigmentary anomaly. Apparently the latter was dominant and the deaf-mutism recessive, with different genes for deaf-mutism in the progenitors.

In late years maternal rubella has been found to affect the foetus, producing congenital deafness. Maternal rubella, however, plays a relatively insignificant role in the aetiology of congenital deafness in general.

DIAGNOSIS

That the diagnosis of deaf-mutism in infancy is a difficult matter is common knowledge to all paediatricians. The deaf baby gurgles and coos in normal fashion, and is not mute. In fact 'deaf and dumb' children are rare. The surest sign of deafness in infancy is delay in the development of speech. If the parents are suspicious of deafness, the suspicion is generally well-founded. In any child over the age of 18 months, where there is no normal speech development and no imbecility, impairment of hearing must first be excluded. Strange to relate, parents often interpret baby sounds as various words of speech, and will not admit any early speech difficulty until the age of three or four years, when abnormal behaviour patterns are manifested. The children adopt a self-willed, intractable, aggressive attitude and cry repetitiously in a sharp, strident way. Unfortunately, it is very unusual for audiometry to be successfully employed for diagnostic purposes under the age of five years, although there is a promising technique now being investigated which uses the principle of the conditioned reflex and which will no doubt eventually accurately measure auditory acuity in children after 10 months of age (Bakwin, 1950). Actually for accurate diagnosis audiometry is essential, because regional deafness may easily be missed when the clock, watch, tuning fork or voice is used. When there is an impairment in the mid-high range, then it is difficult to distinguish differences in consonants of words such as bed, led, said, dead, etc.

In the usual case of congenital deaf-mutism the child is 'bird-witted', very intelligent and dexterous. It spontaneously develops lip-reading technique, and because it may sometimes say 'mum' or 'dad', the parents come to believe the child can hear, and is merely neurotic and over-apprehensive. Speech may be defective by omission of sounds or syllables, due to 'islands' of deafness, and in most cases, the condition is inherited as a Mendelian recessive. When both parents have normal hearing and there is deafness in the family, the chance of their child being born deaf is one in four (Crooks, 1947). These children with impaired hearing in both ears often possess 'residual hearing' for loud noises, such as that of an aeroplane, especially if such noises are accompanied by gross vibration. Occasionally, however, because of speechlessness, these children are treated for aphasia, thereby wasting valuable time. The tympanum and external ear appear normal.

Arnold Gesell (1946) has listed signs which suggest deafness in infants and young children, in the order in which they are most likely to develop:

1. *Hearing and Comprehension of Speech.*
   - General indifference to sound.
   - Lack of response to spoken word.
   - Response to noises as opposed to voice.
2. *Vocalization and Sound Production.*
   - Monotonal quality.
   - Indistinctness.
   - Lessened laughter.
   - Meagre experimental sound play and squealing.
   - Vocal play for vibratory sensation.
   - Head hanging, foot stamping for vibratory sensation.
   - Yelling and screeching to express pleasure, annoyance or need.
3. *Visual Attention and Reciprocal Comprehension.*
   - Augmented visual vigilance and attentiveness.
   - Alertness to gestures and movements.
   - Marked imitativeness in play.
   - Vehemence of gestures.
   - (Note that at 6 months of age, the deaf child becomes progressively quieter, but more visually attentive.)
4. *Social Rapport and Adaptation.*
   - Subnormal rapport in vocal nursery games.
   - Intensified pre-occupation with things rather than persons.
   - Inquiring, sometimes confused or thwarted facial expression.
   - Puzzled and unhappy episodes in social situations.
   - Suspicious alertness, alternating with co-operation.
   - Markedly reactive to praise and affection.
5. *Emotional Behaviour.*
   - Tantrums to call attention to self or need.
   - Tensions, tantrums, resistances due to lack of comprehension.
   - Frequent obstinancies, teasing tendencies.
   - Irritability at not making self understood.
   - Explosions due to self-vexation.
   - Impulsive and avalanche initiatives.

Deafness in early infancy may result from meningitis, influenza, scarlet fever, whooping cough and measles, and may be mistakenly regarded as being congenital if not carefully investigated. Both ears are usually affected, and after meningitis, the deafness which results is generally complete. Mumps may cause a meningoencephalitis, which attacks the labyrinth of one or both ears, usually causing unilateral deafness. Congenital syphilis may also cause deafness by catarrhal otitis, associated with 'snuffles'.

The writer attempted in 1948 to analyse the records of the St. Vincent's School for the Deaf, Johannesburg, but unfortunately details of admitted cases were very meagre. Out of 170 children, 138 were classified as congenitally deaf, while in 42 cases the cause of deafness was given as 'post-infective' or acquired:

Acquired Deafness	*No. of Cases*
Meningitis	25
Mastoid, abscess in ear, 'ear trouble'	4
Measles	4
Whooping cough	1
Chicken pox	1
Tetanus	1
Encaphalitis	1
'Nerve deafness'	4
'Progressive deafness'	1

Of the 138 congenitally deaf children, the pre-natal histories obtained from the mothers on the child's admission were inadequate and no mention was made of rubella during the pregnancy. Figures obtained by Hughson *et al.* (1939) in Pennsylvania also show a vast preponderance of congenital cases over acquired in an institution for deaf children.

APHASIA

Congenital aphasia occurs in children and, of course, such children are not improved by mechanical hearing aids. There are several types of aphasia.

Auditory-verbal agnosia (inability to appreciate the meaning of words, though hearing them clearly) is a condition quite easily diagnosed as deaf-mutism. Such children are alert, often over-active, purposeful, investigative, but retiring and unsocial. They respond to unusual noises, but are inattentive to speech. The basis may be organic or functional, the prognosis being usually better, with treatment, in the latter type of case. Without treatment, all such cases show apparent mental retardation.

Syntactical aphasia, the main disability is to appreciate the correct relationship of one word to another, although hearing is quite clear. Such children produce 'jargon' speech, simulating mental defectiveness or deaf-mutism. Their hearing is, of course, intact.

Amnesic aphasia. Normal hearing and comprehension is present, but the right word cannot be recalled. The child can explain what he is seeing, and for what purpose an object is used, but not name it. The condition is tinged with emotional disturbance.

Motor aphasia. The child with motor speech delay (Broca's aphasia), in contrast to the word-deaf child, evidences considerable understanding of speech, and does not exhibit that striking auditory inattention. He tends to concentrate more on doing things. Rudimentary conversation is laboriously attempted and failure is inclined to cause emotional disturbances and frustration. Mild cases may clear up spontaneously, or speech is developed in lisping or baby fashion.

In the diagnosis of deafness, and the aphasias, local conditions must be excluded, e.g. cleft palate, etc., and anatomical defects such as those following cerebral tumour, encephalitis, meningitis, diphtheria, the prognosis varying with the nature of the lesion. Some children acquire jargon or unintelligible speech due to bad training and environmental conditions, and improve in nursery schools; in others there is an anatomical defect of the ear, brain or cerebellum. Audiometry, when practicable, is invaluable.

DEAFNESS INVOLVING THE AUDITORY APPARATUS

Where the auditory apparatus is involved, and acuities are low, the voice may be low, monotonous, metallic and words are poorly enunciated and badly understood. When high or low frequency sounds are not properly appreciated, speech is correspondingly affected by omission of sounds and syllables. The individual with conduction deafness hears his voice magnified by bone conduction in his own skull and hence his voice tends to be low. The perception deaf individual, in whom the inner ear is affected, speaks very loudly because he cannot hear his own voice, and inflection is bad for the same reason.

Individuals with nerve-type deafness often hear sounds in the lower range reasonably well, but may not hear well enough in the middle and upper registers to distinguish many speech sounds. It appears that the number of children with all types of deafness who can be helped to use their residual hearing is considerably greater than was formerly believed to be the case. Total hearing loss appears not to exceed 5% of cases as determined in a Pennsylvania School for Deaf. (Hughson *et al.*, 1939.)

DEAF-MUTISM FOLLOWING MATERNAL RUBELLA

In the original Australian series reported, subsequent anomalies were anticipated in children apparently normal at the time, and sure enough they occurred, amongst them being deaf-mutism, which is difficult of diagnosis at 18 months or even two years.

Of Swan, Tostevan and Black's original seven cases of deaf-mutism (Swan, 1944), five were female and two were male. Martin (1945) and Hopkins (1949) also found a preponderance in females. Two of the original cases had congenital heart disease as well. Generally speaking they were not totally deaf, but could hear shrill notes such as train whistles, but rarely the spoken word. Speech, as expected, was either absent, or limited to a few words, such as 'mum' and 'dad'. In no case was there a history of deaf-mutism, but in one case there was a family history of adult deafness. The impression was gained that bone conduction was much better than air conduction for high notes. The external canals and tympanic membranes were not abnormal and one child improved much with lip-reading instruction and battery-aid, commencing at 2½ years of age.

Swan *et al.* (1946) commented on the fact that deafness may be complete or partial, involving the middle or inner ears. If complete, the mutism is secondary. If incomplete, speech may be delayed or imperfect owing to 'small islands of deafness'. The autopsy findings in one case showed no differentiation (in both ears) of primitive cells to form the organs of Corti.

Werthemann (1948) confirms that histologically there is no differentiation of the primitive cells of Corti's organ. He also states that the acoustic nerve and spiral ganglion are well developed, and the basilar membrane and bony spiral lamina are easily identifiable. Vascularization of the striae vasculares is somewhat poor and the tectorial membrane is rudimentary, being surrounded by nucleated flat cells. Reissner's membrane is not evident, but the middle and external ear remain normal.

The severity of the rubella attack in the mother appeared to have no relation to the severity of the child's damage to hearing. (Carruthers, 1945; Clayton-Jones, 1947.) Most of the children examined by Carruthers gave some evidence of hearing over the tone range from 512 to 2048. Nine patients were given caloric labrynthine tests, with results that showed little deviation from normal, except that there was no vomiting, even though nystagmus was induced. Welch (1945) drew attention to the fact that in Australia the highest incidence of deaf mutes born in any year since 1930 occurred in 1938, and of these, in 34 cases was there a history of German measles in the mother during first two to four months of pregnancy. The history of 13 others was doubtful.

Clayton-Jones (1947), who investigated post-rubella deaf children, found that all were born between August and February. These months seem related to the periods of prevalence of rubella (March-July), allowing of course for the added period of gestation.

Vickery (1945) studied 21 children of mothers who had rubella in the first three months of pregnancy. Of these, only two had congenital cataract, and most of them

showed failure to thrive, difficulty in management, and not one could put sentences together. Eleven were undersized and underweight, and 13 showed cardiac lesions with murmurs, praecordial bulging, and on X-ray examination, left ventricular dilatation. In one case, a patent ductus was successfully ligated by operation, and the murmur subsided.

Vickery said that most of the 21 deaf children had general nervous instability. They would like awake for hours during the night, especially during the first two years of life. They were unable to concentrate, and showed a peculiar fleeting, prying interest in things. Not one of these cases was totally deaf, but all had impairment of hearing to the extent that they could not comprehend what was said to them. During the fourth year of life, the concentrating powers of most of them had greatly improved, and many of them were learning to co-operate with hands and eyes, although hearing and speech were still much retarded. Dr. Vickery regarded the future outlook as being reasonably good for those whose physique had not been greatly retarded by their cardiac lesions, and it seemed that they might be taught some useful manual trade. He even felt that many would learn to speak. Carruthers urged that speech should be encouraged as early as possible, and Bakwin (1950) states that hearing aids should be used as early as possible in all cases where deafness is not total. Apparently some children are able to use these aids at two to three years of age, if the intelligence is not affected, although six or seven years is the usual period. Modern instruments give a gain of 40 to 50 decibels.

Hopkins (1949) investigated statistically 92 post-rubella deaf children and compared them with 61 deaf children whose mothers had not had rubella during pregnancy. Both groups were also compared with their respective sibs. From the data obtained, she concluded that the arrest in development of the rubella-deafened children was not due to the deafness *per se*, but to the general after-effects of the virus infection on the organism as a whole.

Clayton-Jones (1947) found that deaf children with a maternal history of rubella commonly had bilateral, incomplete inner-ear deafness usually fairly uniform throughout the frequency range. The audiograms showed no evidence of islands of hearing and the deafness was fairly equal in degree in both ears. Hopkins (1949) in a larger series of post-rubella deaf children found that 53 were profoundly deaf, and 38 were partially deaf.

Patrick (1948) graded 34 cases of post-rubella congenital deafness according to severity. In 27 the degree of deafness was so bad as to 'require education by methods used for deaf children without naturally acquired speech or language'. Two cases even with 'the help of a favourable position in class, individual hearing aids, or tuition in lip reading, fail to make satisfactory progress in ordinary classes in ordinary schools'. One case with the above assistance could make satisfactory progress in ordinary classes in ordinary schools. Only four cases in the series had such slight disturbance in hearing as not to require assistance at school and could make satisfactory progress.

Clayton-Jones (1947) found that in 36 post-rubella deaf children difficulty in feeding was commonly reported, and examination showed a tendency to deformity of the jaw, pigeon-chest and atonic musculature; but the intelligence of these children seemed normal and no cataract or definite heart lesion was detected in any case. These patients were investigated in institutions for deaf children. In 13 cases the maternal rubella had been diagnosed by a medical practitioner before the child's birth.

Hopkins (1949) investigated 92 post-rubella deaf children. Ten children born of mothers with rubella during the first two months of pregnancy had congenital ocular defects including cataracts, unilateral or bilateral. None of the children born of mothers having rubella during the third month of pregnancy had any reported ocular defects. A total of 30 post-rubella deaf children out of 92, born of mothers who had rubella during the 'first trimester of pregnancy, were also reported to have congenital heart conditions', which however were not always accurately described. Four of the children out of the whole series were mentally defective, and two had spastic paralysis; two were treated for congenitally dislocated hips; one had umbilical hernia; one had obstruction in the penis; one had hypospadias, and one had a pilonidal dimple. A number of children had several defects other than deafness, but for a total of 53 children the only reported defect was deafness (out of 92 cases).

Miller *et al.* (1949) found an apparently lower incidence of congenital deafness after maternal rubella in the United States as compared with Australia. They attribute this discrepancy possibly to the fact that reports were obtained from specialists whose interest may have been restricted; also the difficulty in diagnosing deafness and mental deficiency in infants. Clayton-Jones (1947) investigated 19 cases and found that the deafness had been recognized in three cases before the first year of life, but in the remaining cases was only recognized from one to four and a half years after birth.

Stage of Pregnancy when Rubella was Contracted. Of the 18 cases of deaf-mutism reported by Carruthers (1945) the mother had contracted rubella—

In the first month of gestation	2 cases
In the second month of gestation	10 cases
In the third month of gestation	4 cases
In the fourth month of gestation	1 case
In the sixth month of gestation	1 case

In Queensland, Winterbotham (1946) investigated 34 congenital deaf-mutes and found that the mothers had suffered from German measles in all instances, at some stage during the first four months of gestation. In 11 of the children a cardiac abnormality was also present.

In England, Martin (1945, 1946) reported on 36 cases of congenital deafness in which there was a history of maternal rubella at some stage during the first four months of pregnancy.

Analysing the combined work of several authors, Aycock and Ingalls (1946) give an average figure of infection at nine weeks of pregnancy for deaf-mutism. To cause combined cataract and deafness, the maternal rubella occurred in the first month in one case, and in the second month in another case.

Hopkins (1949) found that out of 92 post-rubella deaf children, in 10 babies with congenital ocular defects the mother had contracted rubella during the first two months of pregnancy.

Swan and co-workers (1946) noted that deaf-mutism and cataract did not commonly occur together. They found, in

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fact, that deaf-mutism occurred three times more frequently than cataract. Several theories were advanced. One was that the 'cochlea aanlage might be more vulnerable to virus infection for a greater period of time'. Another theory was that there was a higher mortality rate amongst cataract cases, causing early elimination from statistical reckoning. Swan (1949) gives a table of 24 cases collected from the world literature, where deaf-mutism occurred concomitantly with cataract. The maternal rubella had in all cases occurred within the first two months of pregnancy (13 in the first month and 11 in the second month). The same author gives another table relating to 226 cases of congenital deaf-mutism irrespective of whether there were concomitant defects or not. These cases were virtually confined to children whose mothers had contracted rubella during the first four months of pregnancy and the highest incidence of these cases was in the second and third months.

Aycock and Ingalls (1946) further extracted the following average periods of pregnancy for post-rubella anomalies:

For cataract	6 weeks.
For deafness	9 weeks.
For cardiac abnormalities	5–10 weeks.
For deformed teeth	6– 9 weeks.

They quoted Carruthers, 'in the first six weeks, foetal damage may be widespread, and include the eyes, both divisions of the ears, the heart, and perhaps many other parts. After the sixth week, the eyes may escape, the heart may be spared, and the semi-circular canals may become normally developed; but the cochlea is still likely to be damaged'.

Clayton-Jones (1947), in post-rubella children found in no case a history of maternal infection after the first four months of pregnancy. Nor did he find an obvious tendency to premature birth amongst such children. His census was very small, however (20 cases), and Hopkins (1949) in a larger census found a definite tendency to premature births, especially where the maternal infection had occurred in the first month of pregnancy.

HANDLING OF POST-RUBELLA DEAF CHILDREN

Unfortunately many post-rubella children are mentally defective, but congenital deafness *per se* may produce a pattern suggestive of feeble-mindedness. The ordinary intelligence tests are not effective, and the most satisfactory of these are performance tests such as picture completion tests, form-board tests, block designs, etc. The Good-enough 'draw a man' test is fairly good at 4-5 years (Silver, 1950; Gesell, 1940), but the Pintner-Paterson (1923) and Pintner non-language tests are regarded as the most reliable for the deaf.

It is again to be emphasized that whenever a child does not commence talking at the expected age, or whenever its speech is unintelligible, or when simple words appear meaningless to him, a careful investigation of the auditory powers should be instituted. It should also be borne in mind that a deaf child often gives some kind of 'bluff' response whether he hears or not.

The congenitally deaf have great difficulty in learning to read or write. Some never acquire these abilities and school progress is painfully slow. Many deaf children have, however, attained academic success in spite of their handicap.

There is no consistent personality pattern amongst deaf children; these unfortunates vary much in behaviour depending on parental attitudes, home environment, and ability to adjust socially. When loss of hearing amounts to 15 decibels or more, difficulties tend to appear in adjustment (Bakwin, 1950). Bakwin further notes that an important factor tending to make a child feel rejected is the likelihood of his being sent to an institution, especially if his normal siblings remain at home. Schooling for deaf children should ideally begin very early, even at two or three years in nursery groups, and the early use of mechanical aids is advised. Of course, parental embarrassment and feelings of guilt need to be contended with, and guidance or reassurance is necessary. During the early years the deaf child adjusts well in the house, and learns with great facility except where language is concerned, and in this respect the parents should be guided to help the child. Because there is so often some residual hearing it is important to expose these infants from very early to a constant flow of language, just as if the child were normal in hearing capabilities. Bakwin (1950) cites that the mother should talk close to the child's ear and objects should be named and then pointed to. The speaker's head should be steady, in a good light, on a level with the child's face, and speech should be a little more slow than usual.

Matching one thing to another is employed in education and the child's attention should be drawn to various other sounds of everyday life, such as motor horns, church bells, etc. Apart from speech difficulties, the deaf child of normal intelligence is not at a great disadvantage, but actual teaching of speech is best left to trained individuals. For reading instruction, books should be simple at first so as not to discourage the handicapped child. If the child is bright, the ability to read is a wonderful asset, and fortunately only a few post-rubella children are blind as well as deaf.

The deaf child, like most handicapped children, should be loved but not spoilt or pitied. Punishment should never be administered for default unless it is perfectly clear that the child is disobedient through sheer 'naughtiness' and not through lack of understanding on account of his deafness. Full acceptance of the child in the family, by the family, is ideal. Unfortunately, economic and other necessities force many deaf children into institutions. At St. Vincent's School for the Deaf in Johannesburg it has been the experience that deaf children, who are so often frustrated and 'difficult' at home, become easy to handle in the institution, and learn readily. (Personal communication from the matron.)

SUMMARY

1. In the vast majority of cases of deaf-mutism, the aetiology is genetic in origin. The mutism is secondary to the deafness.

2. In a minority of cases, the aetiological factor is an early postnatal acquired infection. Maternal rubella in the first four months of gestation may be followed by congenital deafness in the child, apparently due to defective development in the organ of Corti. Maternal rubella, however, plays a relatively insignificant role in the causation of deaf-mutism in general.

3. The diagnosis is difficult to make in early life, and deafness often simulates mental deficiency or behaviour disorder. Aphasias should be differentiated from deafness, as hearing aids are useless in these cases. True mental deficiency or microcephaly is not infrequently associated with post-rubella congenital deafness.

4. Post-rubella deaf-mutism is usually bilateral, and may be complete or partial, sometimes being associated with other congenital defects, notably cardiac lesions.

5. Unilateral or bilateral cataract or ocular defects may be associated with deafness, particularly if the mother had contracted rubella during the first two months of pregnancy, but fortunately the association occurs not too commonly.

6. Many post-rubella deaf-mutes are undersized and dystrophic.

7. Instruction in lip-reading, individual tuition, and the use of hearing aids should be commenced as early as possible in deaf-mutes. Social adjustment within the family should be aimed at.

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ADAPTATION OF AN ORTHOPAEDIC TABLE FOR USE IN CHEST SURGERY

IVAN BARNAT, F.R.C.S., AND A. A. CILLIERS, M.B., CH.B., D.A.
Durban

The face-down position is becoming ever more popular for lobectomy and pneumonectomy (Fig. 1). In this position the bronchi drain naturally and freely without overflowing into the opposite side. Parry Brown apparently devised this position in about 1940, but it did not meet with popularity at the time, apart from its use by Holmes-Sellors. For the last few years Holmes-Sellors has been using the face-down position with the patient lying on an ordinary operating table with a cushion under the chest and another under the pelvis, and the patient's face turned towards the operated side. Overholt has devised a special table for this position which has one big advantage in that the abdomen is left free and unencumbered (Fig. 3), thus allowing easy and natural respiration. In addition, the face is not turned to the side but is supported in the natural position facing straight down to the ground. This obviates any unnatural pressure on or obstruction of the trachea.

On the Overholt table the patient rests in the prone position, purchase being taken by the pelvis and by a cushioned support under the upper chest just below the clavicles. Earlier he had used a shoulder brace to maintain this position, but this was found to be liable to produce nerve palsies and supports on the bony cage of the thorax are now preferred. The face and head are supported on a special rest and there are also supports for the arms.

The advantages of the face-down position as enumerated by Overholt are as follows:

1. It is the most favourable for the natural drainage of bronchial secretion. Secretions that do not spontaneously flow out can be aspirated easily. Flooding of the contralateral lung, or of the uninvolved lobes of the same side is far less likely.

2. The range of the thoracic cage and diaphragmatic excursion is greater than is possible in the side or lateral position.

3. The amplitude of mediastinal swing or displacement is less.

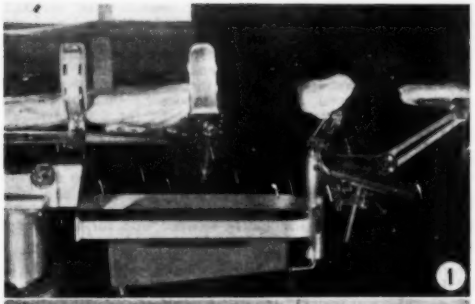
4. The exposure of the posterior aspect of the hilum is facilitated and the bronchus can be clamped at an early stage in cases of pneumonectomy, and with minimal dissection and lung manipulation. This is a great advantage, especially when the lung is densely adherent.

5. The weight of the lung allows it to fall forward, eliminating the necessity of lung clamps and the use of traction during the section. This in turn practically eliminates cardiac irregularities, bradycardia or cardiac stand-still.

6. In the event of serious haemorrhage from the hilum, the blood flows away from its source, thus permitting it to be controlled with far greater ease than is possible in the lateral position.

7. Hilar dissection is far easier as the mediastinum remains central and the hilum is nearer the surface. In the lateral position the weight of the mediastinum tends to cause it to fall away from the surface and it lies on the underlying lung, which is naturally at a disadvantage.

Until the arrival of our Overholt table we had devised an attachment to a Hawley orthopaedic table as a substitute. The patient's lower limbs and pelvis are supported on the top of the orthopaedic table and the head and chest on the attachment which is fitted to the table in place of the normal proximal support (Fig. 2). The chest is supported on two adjustable cushioned supports, either of which can be raised or lowered to ensure accurate fitting and that the operated side is slightly lower than the normal. This is an additional precaution to prevent over-



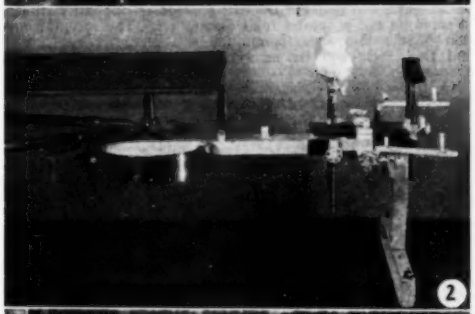


Fig. 1. Overhold-Comper Table.
Fig. 2. Modified Orthopaedic Table.
Fig. 3. Patient on Modified Orthopaedic Table.

flowing of bronchial secretions to the contralateral lung. The forehead is supported on a cushioned support with the head in slight flexion and the face pointing anteriorly. This head support is again fully adjustable to allow for accurate fitting. The patient is maintained in the Trendelenburg position, which can be increased by an added cushion under the pelvis. Adjustable rests are provided for the arms supporting the forearms, inflexion making the arms available for intravenous therapy, blood pressure readings, etc. This also allows the scapulae to fall forward and thus facilitates entry into the chest. As mentioned, all attachments are adjustable to allow for accurate fitting.

Our anaesthetic procedure is as follows: A cannula for intravenous therapy is tied into a suitable vein, preferably in the forearm. The patient's throat is cocainized and intubated under Sodium Pentothal. A face mask is applied, allowing the endotracheal tube to protrude through the opening to which the angled connection from the anaesthetic machine is fitted. Thus suction by catheter through the tube is facilitated and is applied when required. The patient is now rolled from his back into the prone position on the table and the position carefully adjusted to ensure its accuracy and that there is no pressure or obstruction to the airway. The arms are carefully bandaged to the special supports and a strap is placed over the pelvis to ensure the stability of the patient.

The chest is entered through a posterolateral incision with resection of the 6th rib in most cases and shingling of other ribs as necessary.

This adaptation has served us very well and it has one great advantage over the Overholt table in that it is easily portable and can be fitted to any Hawley table.

We have used this position in approximately 50 cases of lobectomy or pneumonectomy for tuberculosis and in no case has a post-operative spread developed in the contralateral lung, or in the remaining lobes in cases of lobectomy. In addition, this position has been used in many cases of resection for lung abscess, bronchiectasis, carcinoma, etc., many of these having profuse bronchial secretions. In no case has there been difficulty with the disposal of these profuse secretions and in no case has a bronchial blocker, with all its attendant difficulties, been necessary. No major anaesthetic difficulties were encountered and a clear airway was easily maintained at all times. Patients have tolerated these major operative procedures much better than in the lateral position and it was never necessary to interrupt the operation on account of anaesthetic difficulties.

Further statistical details will be presented in a later communication.

VERENIGINGSNUUS : ASSOCIATION NEWS

MINUTES OF A MEETING OF THE FEDERAL COUNCIL OF THE MEDICAL ASSOCIATION OF SOUTH AFRICA, HELD AT MEDICAL HOUSE, 5 ESSELEN STREET, JOHANNESBURG, ON 12-14 OCTOBER 1950

Present:—*Border Branch*: Dr. A. Haddad, Dr. R. Schaffer.
Cape Western Branch: Prof. J. F. Brock, Dr. J. P. de Villiers, Dr. A. I. Goldberg, Mr. L. B. Goldschmidt, Dr. T. Shadick Higgins, Mr. M. Cole Rous, Dr. J. H. L. Shapiro, Dr. A. W. S. Sichel.
East Rand Branch: Dr. E. Meltzer, Dr. E. W. Turton.
Natal Coastal Branch: Dr. H. Grant-Whyte, Mr. A. G. Sweetapple.
Natal Inland Branch: Dr. S. Disler, Dr. J. G. M. Richter.
Northern Transvaal Branch: Dr. C. M. Grundlingh, Dr. J. H. Struthers, Dr. J. H. Sypkens, Mr. C. G. L. van Dyk.
O.F.S. and Basutoland Branch: Dr. D. Serfontein.
Southern Transvaal Branch: Dr. J. A. Bell, Dr. J. Black, Dr. L. I. Braun, Dr. R. Geerling, Dr. C. A. H. Green, Dr. T. Schneider, Dr. Maurice Shapiro, Dr. L. O. Vercueil.

Transkei Branch: Dr. J. D. Joubert.
Ex Officio: Dr. J. H. Harvey Pirie, Immediate Past-President; Dr. J. S. du Toit, Honorary Treasurer.
In Attendance: Dr. A. H. Tonkin, Medical Secretary.
The Editor, Dr. H. A. Shapiro, was also present.

THURSDAY, 12 OCTOBER

The President, Dr. A. W. S. Sichel, declared the meeting open at 10 a.m.

1. *Notice Convening the Meeting*, which had been published in the *Journal* of 2 September 1950, was taken as read.

2. *Proxies*: The Medical Secretary read the following Proxies which had been handed in: Dr. J. P. de Villiers to act for Dr. H. S. Gear; Dr. H. Grant-Whyte to act for Dr. A. Broomberg; Dr. C. A. H. Green to act for Dr. C. G. S. van Heyningen; Dr. C. M. Grundlingh to act for Dr. C. J. Albertyn; Dr. A. Haddad to act for Dr. P. F. H. Wagner; Mr. A. G. Sweetapple to act for Dr. E. W. S. Deale; Dr. D. J. Serfontein to act for Dr. R. Theron.

3. *Apologies for Absence* were received from Drs. B. A. Armitage, A. Broomberg, E. W. S. Deale, E. Britten, J. P. Collins, H. S. Gear, A. C. Schulenburg, J. A. Tarlie and R. Theron.

4. *Welcome to New Members*: Dr. Richter introduced Dr. Disler acting during the absence of Dr. Armitage. Dr. Schaffer introduced Dr. Haddad and Dr. Joubert.

They were welcomed by the President.

5. *Resignation*: The Medical Secretary read a letter from Dr. A. C. Schulenburg in which he indicated that he wished to resign his membership of the Council. The President stated that he had written to Dr. Schulenburg in his personal capacity, expressing appreciation of the long and valuable service rendered to the Association by him. He moved that an official letter of appreciation be sent to Dr. Schulenburg. This was *carried with acclamation*.

6. *Condolence*: The President drew attention to a press report that Dr. Allan B. Taylor of Durban, a former member of Council, had lost his son in action in the American Marine Corps in Korea. He moved that a message of condolence from the Council be sent to Dr. Taylor. *Agreed*.

7. *Minutes* of the Meeting of Federal Council held in Johannesburg on 16, 17 and 18 March 1950, were *confirmed and signed*.

MATTERS ARISING OUT OF THE MINUTES

8. *Conference to Decide Medical Responsibility*: A letter from the Registrar of the S.A. Medical and Dental Council was submitted, from which the Council *noted* that the matter had been submitted to the Central Health Services and Hospitals Co-ordinating Council, from which no reply had as yet been received.

9. *Reports of S.A. Medical and Dental Council Meetings*: The President made a short report, and a recommendation from the Executive Committee that the Head Office and Journal Committee appoint a representative of the Head Office staff to attend future meetings of the S.A. Medical and Dental Council to record items of interest to the Association was debated. Council *approved* the recommendation of the Executive Committee.

10. *British Commonwealth Medical Council*: Members were referred to a report published in the *Journal* of 15 July 1950. *Noted*.

11. *Status of General Practitioners*: The President drew attention to a memorandum which had been prepared by Prof. Brock and distributed before the meeting.

After short discussion it was proposed by Dr. Richter, seconded by Dr. Disler and *resolved* that further discussion be delayed until a later stage of the meeting.

12. *Blood Transfusion by Anaesthetists*: A letter from the S.A. Society of Anaesthetists was submitted, in which was contained the following resolution: 'That where blood transfusion is part and parcel of the anaesthetic service, no charge is made, but where the anaesthetist is called upon to administer a blood transfusion in the absence of a recognized officer of the Blood Transfusion Service he shall be entitled to recover such fee as is usual for that service.'

Considerable discussion followed, during which time various proposals were made which were later withdrawn. Eventually two amendments were made to the resolution of the S.A. Society of Anaesthetists, and Dr. Grant-Whyte proposed, seconded by Dr. Disler, when it was *resolved*: 'That where blood transfusion is part and parcel of the anaesthetic service, no charge is made; but where the anaesthetist is called upon to administer a blood transfusion in the absence of a recognized officer of the Blood Transfusion Service he shall be entitled to receive such token payment as is usual for that service.'

13. *Specialist Registration for Medical Officers of Health*: A letter from the Assistant Registrar of the S.A. Medical and Dental Council was submitted, in which it was indicated that the Specialists Committee of the Council could see no necessity for the introduction of such a speciality. Dr. Black explained the attitude of the Specialists Committee and stated that if the Group wished to put the matter forward with further reasons it would be again debated by the Council. *Noted*.

14. *Relationship between the Medical and Dental Professions*: Correspondence was submitted and a resolution of the Executive Committee that the terms of the memorandum be accepted and that the Council proceed to appoint members to serve on the proposed Joint Committee. The recommendation of the Executive Committee was *accepted* by Council and Drs. Pirie and Braun were appointed to represent the Association.

15. *International Vaccination Certificates*: Correspondence from the Secretary General of the World Medical Association was submitted and the Medical Secretary read the recommendation of the Executive Committee that representations be made to the Minister of Health with regard to the issue of medical certificates for vaccination and countersigning by officials of the Department of Health. Council *accepted* the recommendation of the Executive Committee.

16. *Rehabilitation of Disabled Workers*: The Medical Secretary stated that the Executive Committee had nominated Dr. Struthers to represent the Association at a conference to be called by the Departments of Social Welfare. So far no meeting had been arranged. *Noted*.

MATTERS REFERRED BY THE EXECUTIVE COMMITTEE

17. *Vacancy on Executive Committee*: The President stated that Dr. P. F. H. Wagner had resigned his position on the Executive Committee and that in terms of Standing Order 13 he had appointed Dr. R. Schaffer of Queenstown vice Dr. Wagner. He expressed his appreciation of the work which Dr. Schaffer had done for the Association and his remarks were received with *acclamation*. It was proposed by Dr. Goldberg, seconded by Dr. Black and *resolved* that Dr. Schaffer be appointed to fill the vacancy on the Executive Committee for the remaining period of office of the present Committee. Dr. Schaffer thanked the Council for electing him and said that he would do his best in the interests of the Association.

18. *Payment of Annual Registration Fee*: The President stated that the legal opinion taken by one of the members of the Association had been considered by the Executive Committee and in the light of the opinion received from members of the Committee an editorial had appeared in the *Journal*. Council *agreed* that the matter be noted and that no further action be taken.

19. *Unemployment Insurance Act*: Correspondence was submitted and the President in a short report stated that the Executive Committee recommended that the matter be pursued further by the Committee in collaboration with the Law Society. Council *agreed*.

20. *University of Cape Town Development Fund Appeal*: The President stated that he had been asked by the Principal of the University in his capacity as President of the Association to be one of the sponsors of the appeal. The Executive Committee had agreed that he should do so, and Council *approved* the action of the Executive Committee.

21. *Classified Business Directory*: The Medical Secretary reported that this Directory had been brought to the notice of the Association by the Law Society. The matter had been placed before the Executive Committee which agreed that medical practitioners should not allow their names to be placed in it unless the names of all practitioners residing in the area were included, and that an official notice to this effect had been published in the *Journal* on 17 June 1950. Council *approved* the action of the Executive Committee.

22. *Natal Inland Branch—Amendment of Branch Rule 4*:

The Medical Secretary submitted a letter from the Branch requesting that Rule 4 be amended to make it permissible for new members to be elected on the signing of a form by a proposer and seconder. In conformity with a former resolution of the Council, the Executive Committee recommended that the Branch rule be amended accordingly. Council *agreed*.

REPORT OF THE CENTRAL ETHICAL COMMITTEE

23. *Query—Unethical Conduct*: Correspondence from the Northern Transvaal Branch was submitted regarding the giving of advice to private patients by medical practitioners who were newspaper columnists. The Medical Secretary stated that the Executive Committee recommended that the principle involved be brought to the notice of the members through the *Journal*. Council *agreed* to the recommendation of the Executive Committee and the Editor undertook to write an editorial on this subject.

24. *Revision of Rules Governing Procedure in Ethical Matters of a Branch*: The President summarized the position, stating that in 1940 Federal Council had set up a committee which was still in existence. The committee had had a number of meetings and at at least two of them they had had legal advice. The war had intervened and further meetings had not been held. The question which had to be decided was whether the Rules were to include the question of disputes between members and non-members of the Association. The committee felt that non-members should be excluded. The Medical Secretary read the relevant recommendation of the Committee: 'That these rules shall only apply to complaints made by one member of the Association concerning the professional conduct of another member of the Association.' Council *approved* this recommendation. Council further *agreed* that the matter of alterations to the existing rules of procedure be left to the Central Ethical Committee for consideration and recommendation to Council.

25. *Vacancy on Central Ethical Committee*: The President then drew attention to the fact that Dr. Schulenburg's resignation had caused a vacancy on the Central Ethical Committee and he called for nominations to fill the vacancy. He suggested that as Dr. Schulenburg had been a general practitioner, another general practitioner should be appointed in his stead. It was proposed by Dr. Vercueil, seconded by Dr. Bell and *resolved* that Dr. Sypkens be elected to fill the vacancy on the Central Ethical Committee.

REPORT OF HEAD OFFICE AND JOURNAL COMMITTEE

26. *Service rendered by Dr. Simpson Wells*: The President, in presenting his Report, spoke with appreciation of the service rendered to the Association by Dr. Simpson Wells in acting as Convener of the Central Committee for Contract Practice and as Medical Secretary during the latter's absence overseas. Council *noted* this *with acclamation*.

27. *Post—Assistant Medical Secretary*: The President reported that the Head Office and Journal Committee unanimously recommended that Dr. Michael Tonkin, at present Deputy Superintendent of the Johannesburg General Hospital, be appointed to the post of Assistant Medical Secretary. It was proposed by Dr. Richter, seconded by Dr. Geerling and *resolved* that the recommendation of the Committee be accepted by Council.

28. *Post—Part-time Assistant Editor*: The President stated that the Head Office and Journal Committee had recommended the appointment of Dr. H. J. Walton to the post of Part-time Assistant Editor. This recommendation had been approved by the Executive Committee. It was proposed by Dr. Geerling, seconded by Dr. Disler and *resolved* that the action of the Executive Committee be *confirmed*.

29. *Hamilton-Maynard Memorial Medal*: The President reported that the Committee recommended that the Hamilton-Maynard Memorial Medal for 1949 be awarded to Dr. I. Schrire of Cape Town in recognition of his paper entitled *The Diagnosis of Hyperthyroidism*. Council *approved* this award *with acclamation*.

30. *Rules for the Award of the Hamilton-Maynard Memorial Medal*: The Committee recommended that the word 'best' be altered to read 'most outstanding' in the first paragraph of the rules laid down for this award. Council *agreed*.

31. *Leipoldt Memorial Medal*: The Committee recommended that a Leipoldt Memorial Medal be instituted and awarded for the most outstanding paper contributed by a general practitioner to the *Journal* in any year. After discussion the Committee's recommendation was *approved* and the Council *agreed* in principle to the institution of a fund to endow such a medal. Council further *agreed* that the details of the drawing up of rules should be left to the Head Office and Journal Committee.

32. *S.A. Journal of Clinical Science*: The President reported that the first issue of this new Journal was published in March and thereafter had appeared at quarterly intervals. The Journal had been favourably received and no financial loss had been sustained. Council *noted* this with *acclamation*....

33. *The History of Medicine in South Africa*: The President reported that Mr. C. Graham Botha was making progress with this work and that it was confidently expected that the first 20,000 words would be completed by the end of the year. The author had completed his researches and was making steady progress. The whole volume would be one of approximately 100,000 words. Council *noted* this *with approval*.

34. *Medical Agency in Johannesburg*: Council *noted* that on the recommendation of the Southern Transvaal Branch Mr. J. R. Spofforth had been appointed Agency Manager in Johannesburg from 1 June 1950, and that this appointment was subject to review after six months. It was further reported that the work of the Agency was progressing satisfactorily. The question of an advertising campaign to make the Medical Agency better known to members of the Association was then discussed and it was left to the Head Office and Journal Committee to go into the matter.

35. *Medical Insurance Agency*: The President reported that a tentative beginning had been made regarding this Agency and that it was hoped that when an Assistant Medical Secretary had assumed duty the Medical Secretary would be able to devote more time to building it up. He remarked that much would depend on the co-operation of members of the Association if it was to meet with the success possible for it. *Noted*.

36. *Medal for President's Wife*: It was reported that it had taken some time to reach finality in this matter, mainly owing to the difficulty of finding a suitable manufacturer in the Union due to import control. The matter was in hand and it was hoped that a final report would be ready for the next meeting of the Council. *Noted*.

37. *Alterations to Medical House, Cape Town*: The President reported that owing to the expansion of the activities of the Association during the last five years, the Cape Western Branch had agreed to give up its tenancy of the upper hall so that it might be converted into offices. The Branch had vacated its lower hall at the request of the Association some two years ago. The caretakers had moved out of the flat which they had occupied, and the flat and the hall were to be converted into offices and a board room. The Committee gratefully acknowledged the generous gesture which the Branch had made to the Association and recommended that the Branch be thanked by the Council and that the cost of the alterations required be borne by the Association. Council *agreed with acclamation*. Council further *agreed* that the Committee be given the authority to disburse the amount considered necessary for the alterations.

38. *Salaries of Senior Professional Officers*: The President pointed out that the junior professional scale overlapped the present senior scale and he said that the Committee recommended as an interim measure that the lowest notch of the senior scale be placed at £1,500. There was no immediate need to consider the upper notch. A vote was taken and the recommendation was *carried nem. con.* The President then formally moved the adoption of the Committee's Report as a whole. He was seconded by Dr. Black and the adoption of the Report was *carried*.

39. *Financial Report*: The Honorary Treasurer reported that the audited Balance Sheet and Financial Statement had been published in the *Journal* of 5 August 1950; 1949 had been the first year in which the Association had published a weekly *Journal* and it had proved a financial success. Although there had been certain misgivings when the estimates for 1949 were drawn up, the year ended with an excess of income over expenditure of £4,659. He pointed out that the *Journal* subscription revenue had increased from £16,000 in

1948 (fortnightly *Journal*) to £25,300 in 1949 (weekly *Journal* and increased tariff). He remarked that the advertising was a major source of income. Dealing with the expenditure, the Honorary Treasurer pointed out that various items had been increased, travelling expenses rising from £1,524 to £1,760. Printing in 1948 (fortnightly *Journal*) was £9,941 and it had increased in 1949 to £12,945. Accumulated assets had been £19,669 in 1948 and they had risen to £24,328 at the end of the year under review.

He then presented the estimates for the year 1950. The Honorary Treasurer then moved the adoption of the Financial Report. He was seconded by Dr. van Dyk and the adoption was *carried*.

REPORT OF THE MANAGEMENT COMMITTEE OF THE BENEVOLENT FUND

40. *Constitution*: The Chairman reported that since the last meeting of Council when the new constitution had been accepted the Management Committee had met on three occasions. The Constitution had been approved by the Welfare Organisations Board and the Fund had been registered as an approved Welfare Organization, No. 190 under Act No. 40 of 1947. *Noted.*

41. *Grants for 1950*: The Committee had recommended to the Executive Committee and had received permission to make the following additional grants in 1950:—Mrs. K. R., £60 for the year; Mrs. P. C. L., £30 for the period 1 July to 31 December; Mrs. R. D., £40 for the period 1 September to 31 December; Dr. M. O., £40 for the period 1 September to 31 December. Council *confirmed* the making of these grants. The Southern Transvaal Branch had also recommended that Mrs. C., who was the dependant of a non-member, should be given the balance of the money available for allocation in 1950, namely £23. A ballot was taken according to the Rules and the making of this grant was *approved* by Council.

42. *Interim Grants*: The Committee recommended to Council that the Constitution of the Fund be altered to make it permissive for the Committee to grant interim assistance to members or the dependants of members up to the sum of £25 in emergency; such grants to receive the confirmation of Council at its next following meeting. The Committee thus recommended the adoption of the following clause: 'It shall be within the power of the Management Committee to grant temporary relief to a suitable applicant up to the sum of £25. A report of such temporary grant shall be made at the next following meeting of the Council, where it shall be confirmed.' This was put to the vote and *carried nem. con.*

43. *Money Available for Grants*: The Chairman pointed out that the only money available for grants at present was the amount of interest accruing to investments plus an amount from current contributions equal to half the amount of the interest. It had been found that present-day conditions showed that distress made it necessary to make more money available for distribution, and the Committee recommended that an amount at least equal to the amount of interest be made available from current contributions in addition to the amount of the interest accruing to investments.. After discussion the Council *agreed* to the recommendation of the Management Committee.

44. *Grants for 1951*: The Chairman stated that information had yet to be obtained from the Branches regarding the needs of beneficiaries for 1951. The Committee recommended that when the necessary information had been obtained it should be left to the Executive Committee to approve the Management Committee's recommendations so that the beneficiaries might suffer no hardship through delay. This was *approved* by Council.

45. *Financial State of the Fund*: The Honorary Treasurer stated that a credit balance of £1,360 had been added to the accumulated funds at the end of 1949, bringing the total funds invested to £25,206. The estimated interest on these investments was ± £1,000. He thanked all who had contributed to the Fund during the year. Discussion followed on the question of launching a campaign to increase the capital of the Fund to at least £50,000, and the matter was referred back to the Management Committee to discuss ways and means.

The adoption of the Management Committee's Report was moved by the President, seconded by Dr. Goldberg and *carried*.

REPORT OF THE SUB-COMMITTEE ON THE MEDICAL, DENTAL AND PHARMACY ACT

46. *Division into Separate Medical and Dental Councils*: Dr. Braun reported that he had raised the matter at the last meeting of the Medical Council, when the motion which he had put up had been defeated. *Noted.*

47. *Section 80 of the Act*: Dr. M. Shapiro reported that he had drawn up a memorandum following the last meeting of Council, which had been passed on the instructions of the Council to the S.A. Medical and Dental Council and the Minister of Health. An error had appeared in this report which the Medical Secretary had subsequently put right.

It was proposed by Dr. J. H. L. Shapiro, seconded by Dr. Richter and *resolved* that the memorandum so submitted reflected the opinion of the Council.

Dr. M. Shapiro drew attention to a letter which he had received from Advocate Trollip, K.C., containing a further opinion. This was read and it was proposed by Dr. J. H. L. Shapiro, seconded by Dr. Schneider and *resolved* that a copy of the opinion be sent to the S.A. Medical and Dental Council.

48. *Compulsory Internship*: Dr. M. Shapiro informed the Council that he had telephoned the Registrar of Births, Marriages and Deaths in Pretoria to ask whether an intern could sign a death certificate and that the answer had been a categorical 'No'. He had been informed that with the amendment of the Medical, Dental and Pharmacy Act an intern could not be considered to be a registered medical practitioner for this purpose. Dr. Black stated that the Medical Council had it in writing from the Acting Registrar of Births and Deaths that an intern may sign a death certificate, to which Dr. Shapiro replied that his information was to the effect that this decision had been reversed.

The Medical Secretary was instructed to send an urgent reply-paid telegram to the Registrar of Births and Deaths requesting a reply in writing.

It was proposed by Dr. de Villiers, seconded by Dr. Disler and *resolved* that further discussion be deferred until a reply had been received from the Registrar.

49. *Psycho-Surgery*: Items of correspondence were submitted which were *noted*.

50. *Ethical Rule concerning Benefit Societies*: The Medical Secretary read a legal opinion obtained from the Association's lawyers. Dr. Braun pointed out that Rule 19 of the Medical Council's Ethical Rules had recently been amended in respect of dentists. After discussion it was proposed by Dr. M. Shapiro, seconded by Dr. Black and *resolved* that the Medical, Dental and Pharmacy Act Sub-Committee should seek to obtain from the Registrar of the Medical Council a copy of the proposed amendments which they should consider in the light of the legal opinion obtained. If the Sub-Committee wished to make representations, they should do so through the Executive Committee. It was further proposed by Dr. Black, seconded by Dr. Geerling and *resolved* that the three Johannesburg members of the Federal Council who were on the Medical Council should be present at the meetings of the Sub-Committee in an advisory capacity.

(Council adjourned at 6.10 p.m.)

FRIDAY, 13 OCTOBER

The meeting commenced at 9.10 a.m.

51. *Report of Standing Committee on Health Services*: The Convener, Dr. J. P. de Villiers, asked that this Report be taken in conjunction with the Report of the Parliamentary Sub-Committee. Council *agreed*. He then moved that the Report of the Committee which had been published in the *Journal* of 4 March 1950, be accepted as the policy of the Association. This was seconded by Dr. Geerling and *agreed*.

52. *Status of Parliamentary Committee*: Dr. de Villiers then stated that he felt that the work of the Standing Committee on Health Services had been completed and that any future consideration of this subject should be undertaken by the Parliamentary Committee. In the circumstances he felt that the Standing Committee on Health Services should be discharged with thanks for past services, and that the Parliamentary Committee should be raised from the status of a Committee of the Cape Western Branch to that of a Committee of Federal Council. This proposal was seconded by Mr. Goldschmidt and it was *resolved* accordingly.

53. *Election of New Parliamentary Committee*: The President pointed out that the new Committee would have to consist of Federal Council members but that others might be co-opted without voting powers. After discussion Council *resolved* that the personnel of the Commttee be as follows:—

For the Cape: Dr. J. P. de Villiers, Prof. J. F. Brock, Mr. L. B. Goldschmidt, Dr. H. S. Gear, Dr. J. S. du Toit and Dr. A. W. S. Sichel.

For the Transvaal: Dr. J. H. Struthers, Dr. M. Shapiro, Dr. L. I. Braun, Dr. E. W. Turton and Dr. C. M. Grundlingh.

For the Orange Free State: Dr. R. Theron and Dr. P. Connan.

For Natal: Mr. A. G. Sweetapple and Dr. J. G. M. Richter.

Council further *resolved* that Dr. J. P. de Villiers should be the Chairman and Convener and that Dr. Braun be Vice-Chairman, and that three members of the Committee should constitute a quorum. Dr. de Villiers then formally moved the adoption of this Report, which was seconded by Dr. du Toit and *carried*.

REPORT OF WORKMEN'S COMPENSATION ACT SUB-COMMITTEE

54. *Increase in the Tariff of Fees*: The Convener, Dr. E. Meltzer, reported that the Workmen's Compensation Commissioner had arranged for the fees for work done under this Act to be increased by 7½% from 1 August 1950. This had been published in the *Government Gazette* of July. He stated that the Commissioner had been informed that this would be acceptable if subject to review in 18 months' to two years' time. It was proposed by Dr. M. Shapiro, seconded by Mr. Sweetapple and resolved that Federal Council considers the increase of 7½% in Workmen's Compensation Fees to be inadequate, but endorses the action of the Sub-Committee in accepting the increase on the understanding that the Commissioner will review the position as soon as possible.

55. *Repudiation of Accounts*: The Convener stated that numerous cases had been brought before the Commissioner in order to indicate the hardships and injustice perpetrated on medical practitioners. He stated that the Commissioner must, however, be guided by facts, and apparently every accident is inquired into and verified before being accepted as such. There were numerous reasons for not accepting the validity of an accident, such as negligence on the part of a workman. The Commissioner was bound to protect the Fund whilst not wishing to injure the medical practitioner. Finally he pointed out that medical practitioners must seek protection on their own by obtaining authority from responsible persons supervising workmen wherever possible. *Noted*.

56. *Free Choice of Doctor*: The Commissioner had informed the Convener that it was not within his power to enforce free choice of doctor, nor was he prepared to recommend that this be made an amendment to the Act, for obvious reasons. He, however, was willing to recommend, and actually was recommending, to industrialists that free choice of doctor be allowed to all injured workmen. *Noted*. Dr. Meltzer formally moved the adoption of his Report. This was seconded by Dr. Grant-Whyte and *carried*.

57. *Right of Appeal*: The President shortly summed up the position regarding the publication of an editorial on this subject. He mentioned that the Executive Committee had discussed the matter on the previous evening and was willing to make a recommendation. The Medical Secretary then read the Executive Committee's recommendation and also a statement which had been handed in by the Editor.

It was proposed by Dr. M. Shapiro, seconded by Dr. Black and *resolved* that Council go into committee. After full discussion it was proposed by Dr. Schneider, seconded by Dr. Braun, and *resolved* that Council go out of committee and that the resolution taken in committee be *reaffirmed*. The resolution reads as follows:

'In order to promote that good feeling and co-operation which should exist between two bodies of members of an honourable profession and in a desire to remove an atmosphere which is becoming intolerable to a large number of individuals, whatever their views may be on controversial matters, it is the unanimous feeling of this Council that immediate steps should be taken to find a solution to the problem. The Council thus desires that a meeting be sought between the President of the S.A. Medical and Dental Council and the President of the Federal Council, in an attempt to smooth over the difficulties between the two bodies and to improve their relations.'

REPORT OF THE CENTRAL COMMITTEE FOR CONTRACT PRACTICE

58. *Reduction in Tariff of Fees*: In presenting his Report, the Chairman, Dr. C. A. H. Green, thanked the Medical Secretary for the work which he had done in preparation for the meeting of the Committee. He went on to state that the reduced scale of fees had come into force on the 1st July 1950 for one year, and he pointed out the necessity of obtaining all the information which would be required to bring out a new Tariff of Fees at the end of the year, stating that finality should be reached by May 1951, in regard to future fees. Council *noted* these remarks.

59. *Approval of New Medical Aid Societies*: The Committee recommended and the Council *agreed* that the following Medical Aid Societies be approved:—

(a) African Explosives Medical Aid Society (Johannesburg).
(b) Safmarine Medical Aid Society.
(c) University of the Witwatersrand Medical Aid Society.
(d) Hubert Davies Medical Aid Society.
(e) Reckitt & Colman Medical Aid Society.
(f) East London Municipal Employees' Medical Aid Society.
(g) Alex. Aiken & Carter Medical Benefit Society.
(h) Northern Medical Aid Society.
(i) Wright, Boag & Head Wrightson (Pty.) Ltd. Medical Aid Society.
(j) Norwich Union Life Assurance Society Medical Aid Society.
(k) Natal Coal Owners' (Durban Staff) Medical Aid Society
(l) The Natal Estates Ltd. Medical Aid Society.

60. *Benefit Societies—Rules and Regulations*: The Committee recommended that the minimum capitation fee be raised from 18s. to 22s. 6d. per annum for Europeans and from 12s. to 14s. per annum for non-Europeans. Council *agreed*.

It was also recommended that the procedure followed in Pretoria with regard to the Municipal Benefit Fund, where it was known that the income group earning more than £600 per annum exceeded the 5% laid down in the Rules for Benefit Societies, be confirmed. In this case a higher capitation fee than the minimum was negotiated. Council *agreed*. The Committee further recommended that this should be a precedent for future negotiations with other Benefit Societies where the members earning over £600 per annum exceed 5%. Council *agreed*.

61. *Amendments to the Tariff of Fees*: The Committee recommended that a paragraph be inserted in the Preamble to the Tariff booklet, indicating to medical practitioners that they should not differentiate between which members of Medical Aid Societies they will treat at the Tariff rates and which members they will treat as private patients. Council *agreed*.

Gastroscopic Examinations: Owing to an oversight, the fees for £4 14s. 6d. for Gastroscopic Examination listed in the Tariff should have been £8 8s. for the initial fee (less 10%) and £5 5s. (less 10%) for each subsequent examination, in terms of the resolution of Federal Council in March 1950. The Committee recommended that this should be made known to the Medical Aid Societies. Council *agreed*.

Electrocardiogram: The Committee recommended that as the fee of 19s. for electrocardiogram appeared to be too low in the opinion of practitioners who did this work, the fee should be raised to £1 11s. 6d. (less 10%) for both specialists and general practitioners, and that the Medical Aid Societies be informed accordingly. Council *agreed*.

Dental Anaesthetic Fees: The fees for this item were inadvertently omitted from the new Tariff and the Committee recommended that the fee for a complete dental clearance be £3 3s., and £2 2s. for the extraction of a few teeth only, each less 10%, the general practitioner's fees to be two-thirds of these fees. The Committee further recommended that the matter be taken up with the Medical Aid Societies. Council *agreed*.

62. *Relations with Medical Aid Societies*: The Chairman stated that at the Joint Meeting with representatives of the Medical Aid Societies held last May the establishment of a Joint Committee consisting of the members of the Central Committee for Contract Practice and representatives of the Medical Aid Societies, to deal with matters of principle and difficulties regarding the interpretation of the Tariff, was discussed.

After further discussion, the Committee considered that no useful purpose would be served by the setting up of such a body and recommended accordingly to Council. Council *agreed*. The Chairman stated further that in view of the fact that the constitutions of both the Northern and Southern Councils of Medical Aid Societies provided for the admission of Benefit Societies as members, the Committee recommended to Council that in future the Medical Association would not negotiate with representative bodies of Medical Aid Societies on any matters other than those concerning Medical Aid practice. Negotiations affecting Benefit Societies were matters which concerned only the individual Benefit Societies and the local Branch of the Medical Association of South Africa. Council *agreed*.

63. *Resolutions submitted by the Cape Western Branch*: The Branch had recommended that Medical Aid Societies applying for recognition conform in detail with the rules submitted by the Medical Association of South Africa, it being incumbent on the Society to draw attention to and explain any proposed deviation whatsoever from these rules. Council *agreed*. The Branch further suggested that a copy of the rules be sent to both the Medical Association of South Africa and the Council of Medical Aid Societies. The Committee did not recommend the adoption of this resolution, and Council *agreed* that it should not be adopted. The Branch suggested also that Medical Aid Societies should only be recognized by the Medical Association if and as long as they belong to the Council of Medical Aid Societies. The Committee was not prepared to recommend this resolution, and Council *agreed* that it should not be adopted. The Branch further suggested that any proposed alteration of the rules of a recognized Medical Aid Society should be submitted to both the Council of Medical Aid Societies and to the Medical Association of South Africa for approval and should not be implemented until approved by both these bodies. The Committee was not prepared to recommend the adoption of this resolution and Council *agreed* that it should not be adopted.

64. *Liverpool & London & Globe Insurance Company*: In order to avoid the complication of an independent Medical Aid Fund which would require a proper constitution and rules, the above Company had proposed to achieve the same end by the issue of a special insurance contract granting to members of the staff medical benefits against payment of a monthly contribution. It had been pointed out that the cost of administration would be borne by the Company which would also pay a percentage of the members' monthly contribution. There would be no intention to make a profit out of the scheme. The Association had been asked to approve in principle of a scheme of this nature, but the Committee considered that it could not recommend the approval of such a principle and that the Company staff should form a separate Medical Aid Society. Council *agreed*.

65. *Amendment of Rules to which Medical Aid Societies should conform before receiving Approval*: The Committee recommended that Rule (2) be amended to read:—'In consideration of the granting of a preferential tariff, the Medical Aid Society shall guarantee all medical fees, provided the fees charged do not exceed the rates set out in the Tariff.' Council *agreed*.

66. *Vanderbijl Park Medical Scheme—Trust Deed*: The Committee had considered a Deed of Trust for a Fund to be set up to assist the professional officers of the Medical Scheme in various ways. The Committee disapproved the principles underlying this Fund and recommended that the Augmented Executive Committee of Federal Council in the Transvaal be asked to meet representatives of the body concerned in order to come to some satisfactory agreement. Council *agreed*.

67. *Adoption of the Report*: The adoption of the Report of the Committee was moved by Dr. Green, seconded by Dr. van Dyk and *carried*.

REPORT OF THE SUB-COMMITTEE ON INCOME TAX ASSESSMENTS

68. *Representations to the Committee of Inquiry*: Dr. Bell reported that he and the members of his Sub-Committee had met the Committee of Inquiry into the Income Tax Act in company with an Income Tax consultant, and he outlined the various points which had been made by the deputation. These were *noted*.

69. *Booklet on Income Tax*: Dr. Bell stated that with the help of the Income Tax consultant a booklet would be compiled which would give valuable information to medical practitioners. The fee payable to the consultant for this work would be 50 guineas. It was proposed by Dr. M. Shapiro, seconded by Dr. du Toit and *resolved* that the amount of 50 guineas be expended in this way.

70. *Publication of Report*: It was proposed by Prof. Brock and generally *agreed* that Dr. Bell should furnish the Medical Secretary with the Report which should be circulated to members and published in the *Journal*.

71. *Report of the Sub-Committee to Interview the S.A.R. & H. Sick Fund*: After Dr. Braun had submitted his Report, it was proposed by Dr. J. H. L. Shapiro, seconded by Dr. Vercueil and *resolved* that Council go into committee. After full discussion it was proposed by Dr. J. H. L. Shapiro, seconded by Dr. van Dyk and *resolved* that Council go out of committee. It was then generally *agreed* that the resolution taken in committee be *confirmed*. This was that a letter be written to the Railway Medical Officers' Group expressing the displeasure of the Council at the attitude taken by the Executive Committee of the Group during the negotiations.

72. *Report of Sub-Committee to Advise Controller of Imports*: The Report was submitted and the President drew attention to the valuable work which the Committee had done on behalf of the Association. The Report was *noted*.

73. *Report of Sub-Committee on Post-Mortem Examinations*: Members were referred to the confidential report which had been submitted. This was *noted*.

74. *Report of Sub-Committee for Liaison with the Pharmaceutical Society*: Dr. Vercueil gave a short verbal report which was *noted*.

(*Council adjourned at 6 p.m. and resumed at 8.25 p.m.*)

75. *Report of Sub-Committee to Advise National Road Safety Organization*: Members were referred to the Report in the Annexures, which was *noted*.

76. *Report of Sub-Committee on Mines Benefit Society—Pathological Services*: Dr. Braun stated that there was nothing further to report on this matter and asked that the Sub-Committee be discharged. Council *agreed* that the Sub-Committee be discharged with thanks for the work it had done. It was proposed by Dr. Green and *agreed* that the Pathologists' Group be told that nothing further could be done by the Council and that if they wished to make another approach to the Mines Benefit Society they were at liberty to do so.

77. *Report of Sub-Committee on Registration of Specialists*: Dr. M. Shapiro stated that he did not think anything further need be done by the Sub-Committee as the question of Specialist Registration had been taken over by the S.A. Medical and Dental Council itself. He requested that the Sub-Committee be discharged. Council *agreed* that the Sub-Committee be discharged with thanks for past services, and further *agreed* that future matters which might be brought up in this connexion should be dealt with by the Medical, Dental and Pharmacy Act Sub-Committee.

78. *Report of Sub-Committee on Post-Graduate Education and Examination*: Mr. Goldschmidt presented the Report of his Sub-Committee which was *received with acclamation*. Council then proceeded to debate the recommendations of the Sub-Committee which were *adopted* as follows:—

(1) That Federal Council endorses the S.A. Medical and Dental Council's resolution that 'the Council is not itself concerned to be a teaching or examining body, nor does it consider it desirable that it be officially represented'.

(2) That Council is of the opinion that Universities should remain autonomous and that no statutory body should combine them.

(3) That Council feels that post-graduate teaching should be confined to the Medical Schools for the present.

(4) That Council recommends that a Liaison Committee be established by the Universities to correlate their undertakings with the object of making the best use of clinical material and to prevent overlapping of special courses.

(5) That Council recommends that increased financial aid for medical schools be sought from the Government.

(6) That Council recommends that a College of Physicians and Surgeons be established on a non-profit company basis to conduct, *inter alia*, examinations for qualifying diplomas and for higher diplomas in general medicine.

(7) That Council recommends that registration of specialists should be based on:

(a) Degrees or diplomas indicating a higher knowledge of general medicine or general surgery as distinct from a higher diploma subscribing to a higher knowledge of the speciality alone. A diploma covering both would be acceptable.

(b) Evidence of satisfactory clinical experience in the speciality.

It was then proposed by Mr. Goldschmidt, seconded by Dr. Schaffer and, after discussion, *unanimously resolved* that whereas Federal Council has approved in principle of the establishment of a College of Physicians and Surgeons and whereas the establishment of such a College would be greatly helped if it were organized by a body like the Medical Association of South Africa, Federal Council should sponsor the establishment of a College of Physicians and Surgeons, and that it should appoint a Committee of Members and Fellows of recognized Colleges to work through and in conjunction with the Head Office of the Association until such time as the College has reached a stage where it can conduct its own independent affairs. Further, that Federal Council agrees to utilize the organization of the Medical Association of South Africa to establish the College, and that it advance sums to the College on loan until such time as the College should reach independent financial status.

It was proposed by Dr. Geerling, seconded by Dr. Schneider and *resolved* that Mr. Goldschmidt and Dr. Black be the Association's representatives at the next meeting convened by the S.A. Medical and Dental Council, and that Dr. Brebner be also asked to act as a co-opted member. Council further *agreed* that a copy of Mr. Goldschmidt's Report be forwarded to the Registrar of the S.A. Medical and Dental Council and also published in the *Journal* for general information.

Dr. Green moved a vote of thanks to Mr. Goldschmidt, which was *carried with acclamation.*

79. *Presidency of the Association*: The Medical Secretary read a Notice of Motion under the names of Dr. J. S. du Toit and Dr. R. Theron, which had been presented to the last meeting, reading as follows:—

'By-Law 51 (a):

Change "President" and "Vice-President" to read "Chairman" and "Vice-Chairman".

Consequent on this alteration make similar alterations to By-Laws 42, 44, 49, 55, 56, 57, 60, 61; to the Rules applicable to the Secretary of Council—5, 6 and 8, and the rules applicable to the Treasurer of the Council—4 and 5.

In addition, insert the word "President" in By-Laws 55, 57 and 60, and add to By-Law 62 (a) the words "and elect annually the President and President-elect/Vice-President of the Association".

Finally, in By-Law 29 delete the words "of the Council" from the first and the third lines.'

After short discussion it was proposed by Dr. Pirie, seconded by Dr. du Toit and *resolved* that the Notice of Motion be accepted and sent to the Branches for comment.

80. *Honorary and Emeritus Membership*: Notice of Motion having been given and received and having been debated by the Branches to alter By-Law 6, the Medical Secretary reported that the Branches were in favour of the proposed alteration. He then read the By-Law as amended and it was generally *resolved* that the amended By-Law be approved.

81. *General Practitioners' Groups*: Notice of Motion having been given under the names of Dr. M. Shapiro and Dr. Meltzer to amend By-Law 21, the Medical Secretary read the proposed amendment as follows:—'That By-Law 21 be amended by the deletion of the following words: "but who, by reason of paucity of members and/or geographical distribution, are unable to achieve adequate representation of their special interests through the Branches and Divisions".'

It was proposed by Dr. M. Shapiro, seconded by Dr. Meltzer and *resolved* that the amendment be accepted and passed to Branches for comment.

HONOURS

82. *Association's Gold Medal*: The President reported that at the last meeting of Council a nomination had been received for the award of the Gold Medal to Dr. J. S. du Toit. As a ballot was to be taken, he appointed Mr. Goldschmidt to act as scrutineer with the Medical Secretary. A ballot having been taken, the President announced that the award would be made to Dr. du Toit. On the return of Dr. du Toit to the meeting, he was informed by the President that the award would be made at the Joint Meeting to be held next July. Dr. du Toit's reply expressing appreciation was *received with acclamation.*

83. *Association's Bronze Medal*: The Medical Secretary reported that the Cape Western Branch had nominated Dr. J. C. Gie for the award of the Bronze Medal for services to the Association, the Cape Western Branch and particularly to the Central Committee for Contract Practice. A ballot was taken with Mr. Goldschmidt and the Medical Secretary acting as scrutineers. The President announced that the Council had approved the award. *Acclamation.*

84. *Emeritus Membership*. The Medical Secretary submitted a letter and citation from the Border Branch nominating Dr. G. F. Fismer of Katberg to Emeritus Membership of the Association. Dr. Schaffer spoke in support of the nomination and it was proposed by Dr. Schaffer, seconded by Dr. Haddad and *resolved* that Dr. Fismer be elected to Emeritus Membership.

(Council adjourned at 11.30 p.m.)

SATURDAY, 14 OCTOBER

The meeting commenced at 9.15 a.m.

HEALTH SERVICES

87. *Transvaal*: Dr. Braun reported on the present position in the Transvaal and the changes which had taken place since the last meeting of Council. *Noted.*

88. *Honorarium*: Dr. Braun reported that a number of men in the Transvaal wished to make over their share of the honorarium to the Benevolent Fund, provided they would not be due to pay Income Tax on the amount allocated to them. The Medical Secretary reported on correspondence which had taken place between him and the Receiver of Revenue and stated that he would be visiting Pretoria on the Monday following the meeting to discuss the matter with the Receiver of Revenue and with the Hospital Authorities. It was proposed by Dr. J. H. L. Shapiro, seconded by Dr. Geerling and *resolved* that any money paid over to the Association by honoraries in the Transvaal should be devoted entirely to the Benevolent Fund. .

89. *Cape*: The President reported on the position in the Cape, mentioning that a Liaison Commitee was being set up consisting of members of the Provincial Administration and of the Association. *Noted.*

Dr. Shadick Higgins referred to the position of the Medical Association's representatives on the Central Hospitals Committee, and he was generally assured that no criticism had been levelled against the members at any previous meeting. *Noted.*

90. *Orange Free State*: The Medical Secretary read an extract from a letter from Dr. Theron reporting on the position in the Orange Free State. Dr. Serfontein elaborated on this Report. *Noted.*

91. *Natal*: Mr. Sweetapple presented his Report which he elaborated, stating that the Natal Provincial Administration was to appoint a committee to inquire into the hospital work of the Province. *Noted.*

92. *Visiting Specialists in Natal*: The question of the treatment of private patients by visiting specialists to outlying hospitals was then discussed. The Medical Secretary read the recommendation of the Executive Committee as follows:—

'That Resolutions 1 and 2 put forward by the Natal Coastal Branch be accepted with the incorporation of a ruling that visiting specialists may not see private patients in the out-patient departments of public hospitals whereas they may see them in their own homes or while in-patients in hospital. In view of the peculiar position of visiting specialists in Natal, the rota system is recommended.'

It was proposed by Dr. van Dyk, seconded by Dr. Harvey Pirie and *resolved* that the Executive Committee's recommendation be approved.

93. *Assessment Committees*: The Medical Secretary reported on replies from the Branches. These were *noted.* Regarding those Branches which had not yet replied, it was proposed by Dr. Shapiro, seconded by Dr. Geerling and *resolved* that

they be instructed to submit their tariffs within 60 days, failing which the Association would submit tariffs on their behalf.

94. *"Farming Out"—Conference of Interested Bodies*: The Medical Secretary stated that a conference had been arranged to take place at Compensation House, Pretoria, on the following Monday, and gave the names of the delegates of the various interested bodies who would attend. He stated also that the Executive Committee recommend that Drs. Meltzer, Vercueil and J. H. L. Shapiro be appointed to represent the Association at the conference, and that Dr. Pirie should be asked to preside. It was indicated that Dr. Pirie and Dr. Vercueil would not be able to attend, and after discussion Council *resolved* that the Association should be represented by Dr. Meltzer, Dr. J. H. L. Shapiro and Dr. J. J. van Niekerk. Mr. M. Cole Rous agreed to preside at the meeting.

95. *Alterations to By-Laws—Notice of Motion*: The Medical Secretary read Notices of Motion in the names of Dr. Schneider and Dr. Goldberg, as follows:—

"Delete By-Laws 10 (a) and 10 (b) and substitute by new By-Law 10: "Save as hereinafter provided, subscriptions shall be paid by all members to the Head Office of the Association"."

"Amend By-Law 62 (b) by the deletion of the words "branch of an amount not exceeding 10s. per member per annum" and the substitution of the words "member of an annual subscription"."

These were *noted* by Council.

MATTERS REFERRED TO OR BY BRANCHES

96. *Border Branch—Amoebiasis Control*: A letter from the Border Branch was submitted which was amplified by Dr. Schaffer. The Medical Secretary stated that the Executive Committee recommend that representations be made to the Minister of Health for amoebiasis to be classed as a notifiable disease, and that increased laboratory facilities for its diagnosis should be sought. Council generally *agreed* with the recommendation of the Executive Committee.

97. *Cape Western Branch—Fees for Medical Practitioners giving Evidence in Courts*: A letter from the Cape Western Branch was submitted in which it was suggested that the Minister of Justice be requested to increase the mileage fees paid to practitioners called upon to give evidence in court. The Medical Secretary stated that the Executive Committee had agreed to recommend that a letter be written to the Minister of Justice requesting that the mileage fees be increased to 1s. per mile, and that a copy should be sent to the Minister of Health requesting his co-operation. Council generally *agreed* to the recommendation of the Executive Committee.

98. *East Rand Branch—Mileage Fees*: Correspondence was submitted and Dr. Meltzer stated that the matter had been referred to Council in error. He requested that the item be withdrawn. Council *agreed*.

99. *Natal Coastal Branch—Amendment of Branch Rule 5 (1) (b)*: A letter from the Natal Coastal Branch was submitted and the Medical Secretary stated that the Executive Committee recommended that the amendment of the rule be approved. Council *agreed* to the recommendation of the Executive Committee.

100. *Northern Transvaal Branch—Establishment of a Special Library*: A letter from the Northern Transvaal Branch was submitted and Dr. van Dyk spoke in amplification, stating that the Branch wished to establish a library which would be devoted to the history of medicine. The Branch sought the sympathetic approval of the Council, but indicated that the library itself would be financed by the Branch. The Medical Secretary stated that the Executive Committee recommended that the approval of Council be given to the establishment of this library. Council *agreed* to accept the recommendation of the Committee. It was *further* agreed that if the Northern Transvaal Branch wished to submit an article on the subject suitable for publication, it should communicate with the Editor.

101. *Southern Transvaal Branch—Medical Certificates Prior to Cremation*: A letter from the Southern Transvaal Branch was submitted and this was amplified by Dr. Schneider. After discussion it was *agreed* that the letter from the Branch be *noted*.

102. *Southern Transvaal Branch—Amendment of Branch Rule 4 to Provide for the Appointment of an Assistant Secretary*: The Medical Secretary stated that the Executive Committee recommended that this amendment be approved. Council *agreed* to the recommendation of the Executive Committee.

103. *The Association's Role in Public Affairs*: A letter and memorandum from the Southern Transvaal Branch were submitted. Dr. Schneider spoke on this subject and stated that the memorandum did not necessarily reflect the views of the Southern Transvaal Branch Council. The President stated that it was competent for Branches to appoint their own public relations officers to keep the public informed of medical matters through the medium of the lay press. After further discussion the Council agreed that the letter and memorandum be noted.

104. *Unilingual Advertisements in the Journal*: A letter from the Southern Transvaal Branch was submitted, in which it was suggested that advertisements by Government or other Administrative Departments should be placed in the *Journal* in both languages. After discussion the Council *agreed* that the matter be noted.

MATTERS REFERRED TO OR BY GROUPS

105. *Revised Salary Scales for Medical Officers of Health*: A letter from the Medical Officers of Health Group was submitted and was amplified by Dr. Shadick Higgins. After discussion Council *agreed* that the matter be referred back to the Group for clarification and report at the next meeting.

106. *Orthopaedic Surgeons' Group and the Pensions Department*: A letter from the Orthopaedic Group was submitted. This referred to certain fees laid down for orthopaedic surgeons by the Pensions Department. The Medical Secretary stated that the Executive Committee recommended that the matter be referred back to the Group for negotiation and report back to Federal Council. It was generally *agreed* that the recommendation of the Executive Committee be approved.

107. *Paediatricians' Group—Infant Clinic*: A letter from the Chairman of the Group was submitted. This referred to an infant clinic conducted by a practising paediatrician in a private nursing home. The Medical Secretary stated that the Executive Committee recommended that the Medical Secretary should write to the Group, the doctor concerned and the Medical Superintendent or Matron of the Home, pointing out that it was inadvisable for a practising paediatrician to conduct such a clinic in a private nursing home. Dr. Goldberg moved the adoption of this recommendation. After considerable discussion it was proposed by Mr. Goldschmidt, seconded by Dr. J. H. L. Shapiro and *resolved* that it is unethical for a practising medical practitioner to conduct a clinic in a private nursing home catering only for private patients and open to all doctors. If in the case under examination supersession is alleged, the Group should refer a specific charge to the S.A. Medical and Dental Council. Dr. Goldberg wished that his vote be recorded against this resolution.

108. *Joint Meeting, Johannesburg, 1951*: Dr. Geerling reported progress in the arrangements being made for the meeting. The Medical Secretary stated that the Executive Committee recommended that membership of future Congresses should be limited to members of the Association only. Council generally *agreed* that the Executive Committee's recommendation be adopted.

109. *British Commonwealth Medical Conference, Johannesburg, July 1951*: The Medical Secretary reported that on the invitation of the Council, the British Commonwealth Medical Conference would be held in Johannesburg in the week prior to the Joint Meeting. He gave a short summary of what usually took place at these meetings and stated that the Executive Committee recommended that one of the papers to be read should be devoted to the subject of the Status of General Practitioners. This was *noted* by Council.

MISCELLANEOUS

110. *Worcester School for the Deaf*: A letter from the Principal of this School was submitted. The Medical Secretary stated that the Executive Committee recommended that Council should approve the nomination of Dr. A. D. Keen to represent the Association on the Liaison Committee. It suggested that a direct approach by the School for the Deaf should be made to Dr. Berenstein and that it should be indicated that the Asso-

ciation would be glad to appoint another representative if necessry. Council *agreed* that the recommendation of the Executive Committee should be adopted.

111. *Standard Medical Forms for Insurance Examinations*: The Medical Secretary reported that the Life Offices Association had accepted certain standard forms for its members. As the forms of the various Companies required replacement, so they would use the standard form. *Noted.*

112. *Medical Treatment of Service Personnel from High Commission Territories*: A letter from the Medical Adviser to the High Commissioner for the Protectorates was submitted and the Medical Secretary stated that the Executive Committee recommended that officials and dependants of officials who came from High Commission territories should be treated at Medical Aid Society rates, provided that the High Commission Government made itself responsible for the fees. The Council *agreed* that the recommendation of the Executive Committee should be adopted.

113. *Letter from the S.A. Association of Health and Physical Education and Recreation*: The Medical Secretary presented a letter from this Association regarding Sports Physicians. Council *agreed* that the matter was not urgent and should not be taken.

114. *Nurses' Examination Papers*: The Medical Secretary presented a letter from the Chairman of the Queenstown Hospital Board and stated that the Executive Committee had recommended that Dr. Shadick Higgins, who represented the Medical Council on the Nursing Council, should be asked to go into the matter. Council *agreed* that the recommendation of the Executive Committee should be adopted and that Dr. Shadick Higgins should be supplied with a copy of the letter in question.

115. *Salary of the Editor*: The President stated that he had received a note from the Editor regarding his salary. He stated that this letter should have been submitted first to the Head Office and Journal Committee. Dr. Braun proposed that the matter be referred to the Head Office and Journal Committee for consideration. Council *agreed.*

116. *Radiological Group*: Dr. Schneider raised the question of the Constitution of the Radiological Group. The Medical Secretary read a letter from the Honorary Secretary regarding the procedure being carried out in the new elections. Council *agreed* that no further consideration be given to the matter at this stage.

117. *Heart Examination Forms for Insurance Companies*: Dr. Schneider asked for information about this. Council *agreed* that as this matter was not urgent, Dr. Schneider should make further inquiries and raise the matter at a further meeting of the Council.

118. *Date and Place of Next Meeting of Council*: It was proposed by Mr. Sweetapple, seconded by Dr. Schneider and *resolved* that this be left to the Executive Committee. The President stated that the meeting would probably be held in March and would be the last meeting of the present Council as an election would take place towards the middle of the year. The newly-elected Council would probably meet towards November. *Noted.*

119. *Vote of Thanks*: Dr. M. Shapiro proposed a vote of thanks to the President for his conduct of the meeting. This was *carried with acclamation* and the President replied, thanking members for attending the meeting and for their co-operation and patience.

The President added his thanks to the Southern Transvaal Branch for their hospitality during the time of the meeting.

The meeting ended at 1.10 p.m.

* * * *

1951 MEDICAL CONGRESS

At a meeting of the Southern Transvaal Branch of the Medical Association of South Africa held in Johannesburg on Tuesday, 20 February 1951, the question of the holding of a South African Medical Congress was discussed. It was resolved that the Southern Transvaal Branch would invite the Medical Association of South Africa to hold its 38th South African Medical Congress and 17th Annual Scientific Meeting at Johannesburg during the latter half of 1951.

The Medical Association's Constitution lays down that 'at least once a year the Council shall arrange meetings or conferences alone, or in conjunction with other bodies, which shall be open to every member of the Association to attend'.

These meetings 'shall be convened at the same place as the Annual General Meeting of the Association' which is usually held in September or October each year.

A. H. Tonkin,
22 February 1951. *Medical Secretary.*

OFFICIAL ANNOUNCEMENT : AMPTELIKE AANKONDIGING

FEDERAL COUNCIL

Notice is hereby given that a meeting of the Federal Council will be held at Medical House, 5 Esselen Street, Johannesburg, on 12, 13 and 14 April 1951, at 9 a.m.

AGENDA

1. Notice convening the meeting.
2. Proxies.
3. Minutes of previous meeting (circulated).
4. Matters arising out of the minutes.
5. Financial statement by the Honorary Treasurer.
6. Report of the Executive Committee.
7. Reports of other Committees.
8. Reports deferred from the previous meeting.
9. Notices of motion transferred from the previous meeting.
10. New notices of motion.
11. Other business.

A. H. Tonkin,
Medical Secretary.

Medical House,
35 Wale Street,
Cape Town.
1 March 1951.

FEDERALE RAAD

Kennis geskied hiermee dat 'n vergadering van die Federale Raad gehou sal word op 12, 13 en 14 April 1951, om 9 v.m., te Mediese Huis, Esselenstraat 5, Johannesburg.

AGENDA

1. Kennisgewing van vergadering.
2. Volmagte.
3. Notule van vorige vergadering (reeds uitgestuur).
4. Sake vermeld in die notule.
5. Geldelike verslag deur die Ere-Tesourier.
6. Verslag van die Uitvoerende Komitee.
7. Verslae van ander Komitees.
8. Verslae uitgestel van die vorige vergadering.
9. Kennisgewings van voorstelle oorgedra van die vorige vergadering.
10. Nuwe kennisgewings van voorstelle.
11. Ander besigheid.

A. H. Tonkin,
Mediese Sekretaris.

Mediese Huis,
Waalstraat 35,
Kaapstad.
1 Maart 1951.

PASSING EVENTS

FEDERAL COUNCIL MEETING

The meeting of Federal Council which had been tentatively arranged for March will now take place at Medical House, Johannesburg, on 12, 13 and 14 April. Meetings of the Executive Committee and the Central Committee for Contract Practice will be held at the same place on 11 idem. An Official Announcement to this effect appears elsewhere in this issue.

* * * *

Copies of the book *Acute Head Injuries: Their Diagnosis, Prognosis and Treatment* by Mr. W. Welchman, F.R.C.S., are obtainable at the Head Office, P.O. Box 643, Cape Town, the Office of the Southern Transvaal Branch, 5 Esselen Street,

Hospital Hill, Johannesburg, and The Medical School Library, Hospital Hill, Johannesburg.

The price is 2s. 6d. per copy (plus 3d. postage). The proceeds are in aid of the Benevolent Fund.

* * * *

The fourth edition of the handbook *The Sex Hormones* published by Ciba Laboratories Limited is now available. The agents in South Africa, Messrs. Sana Limited, P.O. Box 3951, Johannesburg, have a limited supply of copies of this handbook which they will be pleased to issue on request to members of the medical profession.

* * * *

Dr. and Mrs. B. Ordman left in the *Athlone Castle* on a six months' visit to the United Kingdom and the Continent. Dr. Ordman intends to visit medical schools on the Continent to study the teaching of medicine to undergraduates.

CORRESPONDENCE

THE CANCELLATION OF THE JOINT MEETING—1951

To the Editor: In the daily papers of yesterday, I was horrified to read that the Secretary of the B.M.A. has informed you that they have now finally decided to cancel their annual meeting with us in Johannesburg in July.

The circumstances which have forced the B.M.A. to this conclusion are very plain and easy enough to understand and as a member of our profession I can only express my extreme disgust at the attitude of the responsible Minister. It shows petty ignorance and a total disregard for the feeling of the majority in our profession, in addition to doing irreparable harm not only to our profession but also to the country as a whole.

Surely, the recent sojourn of the Ministers in England and elsewhere should make them understand that the narrow-mindedness displayed over this matter can only do us harm and no good.

Could we not, even at this late stage, again approach the office of the Minister concerned in order to get the assurances required by the B.M.A. so that they might change their mind and still hold the meeting? I am sure if the more moderate members of the Cabinet are approached the problem could still be solved.

My sincerest wish is that this joint meeting will still be made possible.

Izak Z. G. Nel.

60 Mare Street,
Pietersburg.
10 February 1951.

To the Editor: There must be many in the profession who share a sense of deep regret at the cancellation of the proposed joint meeting of the South African and British Medical Associations.

Three main considerations spring to mind:—

1. South African medicine has lost the opportunity of a free exchange of ideas with the overseas delegates, is deprived of the value of contacts thus secured and will be the poorer for the lack of information and discussion of topics, not only of general interest but also directly relating to our particular problems in South Africa.

2. The adverse impression created abroad is deplorable and unworthy of the standards and traditions of medicine in South Africa.

3. An undesirable precedent has been created for possible future international congresses which might be held in this country, and the opportunity to return some of the help and hospitality which South Africans have always enjoyed overseas has been lost.

Finally, one has to view with grave concern the possibility that at international congresses to come South Africans may no longer enjoy the same open welcome which has been theirs in the past.

A. G. Albers.
A. Kipps.
H. G. Owen-Smith.
R. F. Maggs.
H. Muller.
L. Babrow.
W. G. Schulze.
R. W. Pickering.

Cape Town.
16 February 1951.

SICK FUND REMUNERATION (*Sic*)

To the Editor: A recent advertisement in the *Journal* invited Specialists to apply for various appointments to a Sick Fund. No information was given in this advertisement, and in due course, after I had submitted a letter asking for information, I received the following reply:

'APPLICATION—CONSULTING PHYSICIAN

Further to my letter my Committee has instructed me to supply you with the following particulars:

i. The advertiser is the Tramways Employees Sick Fund consisting of 9,600 beneficiaries.

ii. The salary offered is 150 guineas per annum.

iii. There is a panel of seven doctors. Members will not be allowed to consult Specialists unless referred by a doctor on the panel.

iv. *Consultations only*. For operations, members must be referred to a public hospital unless they can afford to pay. That will not concern this Sick Fund, which does not pay for operations. For Nursing Home or Hospital this Sick Fund gives members 5s. per day and most of them cannot afford to pay the balance.

v. Duties to commence within one month of appointment.

An early communication indicating whether or not you are interested in this appointment would be greatly appreciated.'

I do now feel that some sort of protest is indicated at this stage. I am a Consultant Physician and am being asked to be willing to work in such a capacity for this Sick Fund, and as can be seen the sum of 150 guineas per annum is offered! At the first reading of this letter my reaction was that of amusement. I laughed heartily, said a few rude words and threw the letter away. My second reaction, however, was entirely different. I found myself burning with indignation and resentment. To be a Physician to a body of 9,600 people is no light undertaking and one can expect in ordinary times that I should be requested to see at least five people a week from this organization. Therefore in a year approximately 250 or more may be expected to be seen in consultation, and as an appreciable proportion of the cases are cardiac, at least 50 electrocardiographic examinations will, at a modest estimation, be performed. All this for the princely sum of 150 guineas per annum!

Taking the above fees into consideration as a comparative working basis, then *pro rata* the General Practitioners who are associated with this Fund may be receiving approximately 2s. or 2s. 6d. for a consultation or visit to the patient's house. Are we to be led to believe that this is indeed the case?

It is interesting at this stage to note that in September 1949, Federal Council made a recommendation that Physicians should be assessed in the case of Medical Benefit Societies at the rate of 5d. per head per month. Applying this principle to the above Sick Fund, the remuneration would then be in the neighbourhood of £2,500. It will therefore be appreciated how ludicrous the above fees are.

I am naturally not accepting this appointment, but one of the younger Physicians may for obvious reasons accept this position. With the wolf at the door one may be less inclined to turn away 150 guineas. If it were me, I would rather drag the wolf indoors and eat him! The whole concept is wrong. This is slave labour, and all of us, whether Specialists or General Practitioners, will be cutting our own throats if we allow our profession to be prostituted in this manner. I do not know if the situation is legal or not, and neither do I know how we can protect ourselves against this vicious attempt to lower our status and our standard of living. I write this letter as a *cri de coeur* and in the faint hope that my colleagues have some suggestions to offer.

Cape Town. *Red Hooding Ride.*
16 February 1951.

Schering

is pleased to announce that

an important problem of

HORMONE THERAPY

has been solved

by

BUCCAL TABLETS

Schering Buccal Tablets permit intensive hormone therapy without injections. The uniquely efficient absorption of Buccal Tablets through the oral mucosa is due to the remarkable new solid solvent, POLYHYDROL, in which the hormones are incorporated.

IN ADRENAL INSUFFICIENCY: **CORTATE** (Desoxycorticosterone Acetate) Buccal Tablets 2 mg., 30's

IN MALE HYPOGONADISM: **ORETON** (Testosterone Propionate) Buccal Tablets 2.5 mg. & 5 mg., 30's and 100's

IN HABITUAL ABORTION: **PRANONE** (Progesterone) Buccal Tablets 10 mg., 30's and 100's

IN THE MENOPAUSAL SYNDROME: **PROFOLIOL** (Oestradiol) Buccal Tablets 0.25 mg., 30's and 100's

MANUFACTURED IN THE UNION OF SOUTH AFRICA BY
SCHERAG (PTY.) LIMITED JOHANNESBURG
FOR AND UNDER THE FORMULA AND TECHNICAL SUPERVISION OF

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SCHERING

City of Durban

VACANCY FOR SENIOR CLINICAL MEDICAL OFFICER (CITY VENEREOLOGIST): CITY HEALTH DEPARTMENT

Applications are invited for the vacant position of Senior Clinical Medical Officer (City Venereologist) in the City Health Department.

The grade for the position is G.5 (£1,000 × 50—£1,200) subject to the operation of the City Council's Scheme of Deflation of Salaries and Wages, and the appointment will be in terms of the General Conditions of Service and Leave Regulations, and subject to the approval of the Minister of Health. In addition, a cost-of-living allowance is being paid which, at existing rates, will give a total monthly remuneration as follows:—

Salary per annum	*Total Monthly Remuneration (including C.O.L. Allowance)*
£1,000	£93 6s. 6d.
£1,200	£109 5s. 8d.

The duties attaching to the position are:—

(1) Professional and administrative charge of the non-European Venereal Diseases Clinic.

(2) Organization, maintenance and development (under the direction of the City Medical Officer of Health) of the Venereal Diseases control programme in respect of all races throughout the City.

(3) Such other duties as may be assigned from time to time.

Candidates must be well experienced in venereology, and should not be more than forty-five years of age.

The successful candidate may be expected to drive a motor-car in the course of his official duties and should therefore be in possession of the necessary driver's licence.

Applications from registered male medical practitioners, stating age, qualifications and experience, details of military service (if any), and accompanied by copies of not more than three recent testimonials, should reach the City Medical Officer of Health, Gale Street, Durban, not later than 12 noon on Saturday, 10 March 1951.

Personal canvassing for appointment is prohibited and proof thereof will disqualify a candidate *vide* Council's Standing Order No. 1.

A. A. Whitaker
Acting Town Clerk
(4233)

Town Clerk's Office
Durban
16 February 1951

Bridgman Memorial Hospital

(NON-EUROPEAN MATERNITY)

JOHANNESBURG

Applications are invited for the position of full-time Medical Superintendent of the above Mission Hospital. Duties include both clinical and administrative work. Salary £1,000 × 50—£1,200, plus cost-of-living allowance and free house. Applications must be received by 16 March 1951; duties to begin as soon as possible. Further particulars to *bona fide* applicants from Honorary Secretary, 19 Eleanor Street, Fairview, Johannesburg.

Radiological Partnership

Radiological partnership in old-established firm in large rapidly expanding coastal city in South Africa, with ideal climate. Share yielding over £3,200 net per annum. Practice figures increasing yearly; two remaining partners.

The practice does all the radiological work for a hospital of over 400 beds. Rooms and apparatus of the most modern type. Write to 'A. F. C.', P.O. Box 643, Cape Town.

Position Wanted

Recently qualified Groote Schuur nurse desires position as Doctor's Nurse or Receptionist in Cape Town area. Completely bilingual. Write P.O. Box 42, Grabouw, Cape Province.

Public Service Commission

VACANCIES IN THE PUBLIC SERVICE

1. The attention of medical practitioners, registered with the South African Medical and Dental Council, is drawn to an advertisement appearing in the *Government* and *Provincial Gazettes* of this week, inviting applications for the undermentioned posts:—

Post	*Department Administration*	*Salary Scale*
Chief Medical Inspector of Schools	Transvaal Provincial Administration	£1,200 × 50—1,400
Medical Inspector of Hospitals	Cape Provincial Administration	£1,200 × 50—1,400
Senior Pathologist	Health	£1,200 × 50—1,400
Medical Inspector	Health	£960 × 40—1,120
Research Officer in Physical Education	Education, Arts and Science	£960 × 40—1,120
District Surgeon	Health	£720 × 30—900 × 40—1,020
Medical Officer	Health	£600 × 30 — 840 plus privileges of quarters, rations, fuel, light and laundry.

2. In addition to salary a cost-of-living allowance at the rate of £208 per annum (married) and £50 per annum (single) is payable at present.

3. It is emphasized that full and detailed particulars of qualifications and previous experience (including military service) must be furnished but original certificates and testimonials should not be submitted. Application forms (Z.83 and P.S.C. 8 (*a*)) are obtainable from the Secretary, Public Service Commission, Pretoria, to whom filled-in forms must be addressed.

4. The closing date for the receipt of applications is 24 March 1951.

(27464)

Practice for Sale

Well-established Physician's practice for sale. Well-equipped and designed consulting rooms in centre of Pretoria, reasonable rental, premium merely nominal in deceased Estate. Reference books and medical equipment, including Electro Cardiograph and B.M.R. apparatus and furniture can also be taken over and if required also large dwelling-house in Arcadia. Apply: W. F. van der Merwe & Co., P.O. Box 499, Pretoria. Attorneys for Executor Dative.

Radiologist: Cape Town

For sale: A half-share in an old-established Cape Town radiological practice. Average net income over the past three years for the half-share amounts to £3,300. X-ray equipment, radium, furniture and accessories valued at the ridiculously low figure of £700 half-share, for quick sale. Purchase price for half-share £4,000 cash, or terms £2,000 cash and £75 per month, plus 5% interest on the unpaid balance. First genuine offer will be accepted. Write to 'T. F', P.O. Box 643, Cape Town.

To Let

Woman doctor will receive into her quiet home in Rondebosch, Cape Town, patient, either sex, requiring medical and nursery care. Under supervision patient's own doctor.

Large double room opening into covered stoep with open view of Table Mountain. One acre garden, swimming pool. Special diet if necessary. Terms by arrangement. Telephone 6-6627 or write "M. H. E.", P.O. Box 643, Cape Town.

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